



PHD

**How do GPs, Nurse and Pharmacist Prescribers Manage Patients' Emotional Cues and Concerns in Healthcare Encounters?**

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# How do GPs, Nurse and Pharmacist Prescribers Manage Patients' Emotional Cues and Concerns in Healthcare Encounters?

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Ruth Riley

A thesis submitted for the degree of  
Doctor of Philosophy

University of Bath

Department of Pharmacy and  
Pharmacology

July 2014

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"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."

Maya Angelou, writer, poet and civil rights activist  
(1928-2014)

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# Abstract

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In healthcare encounters, patients communicate wide-ranging concerns relating to their health and illness experience, treatment or wider psychosocial world. This research draws upon a normative understanding of patient centred approaches which recognise the clinical and psychotherapeutic value in having the opportunity to talk to someone who will listen empathetically and to have expressed concerns acknowledged and understood.

The aim of this research was to understand how GPs, nurse and pharmacist prescribers manage patients' emotional cues and concerns in healthcare encounters. This research employed a mixed method study underpinned by an interpretative epistemology to understand, in particular, how nurse and pharmacists as 'new prescribers' manage emotionality during consultations in primary care. The study also critically reflected on the value and limitations of the study methodology to explore this topic.

Phase one employed a coding framework to code 528 consultations with 20 GPs, 19 nurses and 12 pharmacist prescribers. The nature and content of patients' cues and concerns and healthcare professionals' responses were coded and analysed quantitatively. Phase two undertook qualitative analysis on a sub-sample of 30 transcribed recordings to understand barriers and facilitators to offering emotional labour during the consultation process.

Phase one found that patients communicate on average 3.4 cues and concerns per consultation and of those concerns expressed, half related to biomedical concerns. Other cue and concern types related to medication, the impact of a patient's condition/symptoms on their day-to-day life and cues and concerns related to psychosocial issues, including job stress, family problems, or bereavement. Phase one found that there were significant differences between the type of positive/missed responses to patients' cues and concerns across the groups. 81% of pharmacists'

responses were coded as positive compared with 72% of nurse prescriber responses and 52% of GP responses. Male GPs were significantly more likely to miss patients' cues and concerns compared to female GPs.

Phase two drew upon emotion work theory and models of patient centred care to identify the ways in which emotions are communicated and managed within healthcare encounters recorded for this study. Phase two identified facilitators (such as attuning to the patient's world, evidence of listening, providing space, validating and legitimising patients' concerns) and barriers (emotional disengagement, task focused and structured/agenda driven consultations) to the employment of emotional labour. These findings identify that a complex inter-play of individual, socio-cultural and political factors have potential to influence the way in which emotionality is managed during the consultation process.

The findings reinforce the importance of patient centred approaches and communication skills training and the need for support, supervision and training to enable healthcare professionals to manage their emotionality and that of their patients.

# Chapter 1: Introduction

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## **1.0 Introduction to the Research**

During a consultation with a healthcare professional, a patient may communicate direct or indirect emotional concerns which relate to their health and illness experience, treatment or wider psychosocial world. Analysis of healthcare interactions has identified that patients can often infer problems or concerns which are referred to as cues which provide a clue or a window into the inner world of the patient (Zimmerman, et al, 2007, Levinson, 2000; Suchman, 1997). Evidence suggests that in responding to and exploring patients' cues and concerns, empathetically, healthcare professionals can gain important information about the patients' biopsychosocial world. For patients, being granted the opportunity to talk to someone who will listen empathetically and have their concerns acknowledged and understood is known to confer both clinical and psychotherapeutic benefits (Zimmerman et al., 2007; Oz, 2001; Levinson, 2000; Elwyn & Gwyn, 1999; Kleinman, 1998; Suchmann, 1997). Additionally, patient satisfaction is positively associated with empathic and patient centred healthcare encounters while patients rate 'humanness' as an important quality in healthcare professionals (Kim et al, 2004; Little et al, 2001; Roter et al, 1987). Furthermore, evidence indicates that healthcare professionals who respond empathically in the clinical encounter are more likely to feel satisfied in their work and are

less likely to experience burnout and stress (Larson and Yao, 2005; Shanafelt, 2002).

Responding to patients' emotional cues and concerns lies within a broader, holistic framework of patient centred and narrative based approaches to healthcare. These approaches encourage health care professionals to attend to patient's stories or meanings of health and illness and to consider the wider psychosocial context of their patient's lives in addition to meeting patients' clinical needs. The benefits and importance of patient centred or narrative based medicine has been endorsed within the literature, policy and educational curricula on healthcare communication (Hasman et al, 2006; DOH, 2004; Silverman et al, 1998) and as an approach to health care practice advocated by the principal professional governing bodies of doctors, nurses and pharmacists in the UK (GPhC, 2012; GMC, 2009; NMC, 2006).

### 1.1 The New Prescribers

In 2006, following a completion of an approved independent prescribing training course, nurses and pharmacists were legally permitted to prescribe independently from a full formulary with the exception of controlled and unlicensed drugs (DoH, 2006). With nurses and pharmacists new to the role of prescribing in primary care, this study was interested in exploring how nurses, pharmacist and GPs manage patients' cues and concerns within the consultation process. While nurses and GPs have played a longstanding role in providing and managing patients' health and treatment in primary care, pharmacists are relatively new to managing consultations with patients in this setting. Consequently, this study was interested in understanding more about the ways in which these three professional groups manage patients' cues and concerns within healthcare encounters in primary care and to identify ways in which their management of emotionality might differ.

The emergence of the 'new' prescribers within a historical and political context of primary care will be discussed further in the following chapter.

## **1.2 Overview of Theory**

This research has drawn upon the following theoretical frameworks and paradigms:

1) The biopsychosocial model of health and illness provides a framework for understanding health and illness experience. This model distinguishes itself from the biomedical model of health and illness which offered a dualistic, disembodied approach to understanding health and illness (Engel, 1977). The theoretical and epistemological basis underpinning this model acknowledges that people experience the world with both body and mind while recognising that the social, emotional and physical dimensions of people's lives influence the way in which people experience health and illness (Engel, 1977; Kleinman, 1998). The biopsychosocial model was later operationalised as an approach and ethos in healthcare by patient centred care which considers and recognises patients' wider needs and narratives within a more dynamic and more democratic consultation process (Epstein, 2005; Mead and Bower, 2000). This model and understanding of health and illness have been employed within a normative framework underpinning this research and is a main focal point of this study and analysis.

2) Hochschild's emotion work theory (1979, 1983) which was underpinned by a social constructionist ontology drew on Marxist and feminist traditions in order to deconstruct and question taken-for-granted knowledge around gendered aspects of emotion work and power of the institution in influencing or owning workers' feelings. While Hochschild's original theory has been developed and adapted for its application within a healthcare setting (Smith, 2012; Theodosius, 2008) its epistemological and ontological roots provide a useful framework for critically understanding the employment of emotional labour within the primary care setting and potential barriers to doing so. This phase of the study is interested in how professionals carry out 'positive emotional labour', a



term coined by Smith (2012) to describe the caring work – clinical, personal and relational skills employed within a patient centred framework (Smith, 2012).

The theoretical framework for this study is underpinned by a social constructionist stance which holds that social reality exists independently and yet is negotiated through or influenced by socially constructed knowledge (Snape & Spencer, 2003). The socially constructed ontological assumptions of emotion work argue that emotion communication and management are largely mediated through social and cultural heuristics or feeling rules (Bolton, 2003; Fineman, 2003). A social constructionist view of emotions holds that what and how emotions are expressed are mediated by the emotion discourse and language available to us and through the process of social interaction and socialised rules which guides us to feeling 'appropriately.' In this way the theoretical and ontological assumptions of these theories offers a more critical lens to view the healthcare encounter in which emotions are communicated and managed within the setting of general practice.

In adopting a social constructionist framework, the healthcare encounter is viewed within its sociological context. The study will therefore be attentive to factors such as how the training of different professionals, or gender of the healthcare professional play a part in influencing the ways in which patients' emotional cues and concerns are managed and emotional labour employed.

Employing this theory also provides a useful framework to make visible the emotional labour undertaken during healthcare encounters with patients while deconstructing taken-for-granted knowledge concerning how feelings are communicated and managed within the healthcare encounter. Moreover, in making emotion work explicit and highlighting the ways in which emotion work is employed during consultations, it enables emotion work to be valued rather than assumed.

The analytic process employed in the qualitative phase has utilised Layder's (1998) adaptive theory which represents a pragmatic and dynamic approach to the realities of the research process and data

analysis. Adaptive theory represents a middle ground between deductive and inductive approaches to data analysis by proposing that while it is important to allow generation of theory from the data, existing ideas, knowledge, experiences and feelings have the potential to inform or shape emergent theory (Layder, 1998).

### **1.3 Overall Aims of the Study**

1. How do GPs, nurse and pharmacist prescribers manage patients' emotional cues and concerns in healthcare encounters in primary care?
2. How do sociological factors (such as gender, age of professional, professional group) and context (such as wider political context, for example, process demands such as pay-for-performance schemes (i.e. the Quality Outcomes Framework) or changing roles and responsibilities within the primary care workforce) influence the ways in which professionals manage patients' cues and concerns.
3. What are the implications of the findings in terms of identifying future support and training needs of healthcare professionals?
4. How do the methods employed in phase one and two compare in exploring this topic area?

#### **1.3.1 Aims and Objectives of Phase 1**

Aim: To compare the nature and frequency of patient's cues and concerns and GPs, nurse prescribers (NPs) and pharmacist prescribers (PhPs) responses to them.

Objectives:

1. To identify the frequency and nature of cues which arise within patient-prescriber consultations

2. To identify whether different prescribers respond differently to patient cues
3. To identify what demographic variables (age and gender of prescriber and consultation length) influence the type of prescriber response to patients' emotional cues and concerns

### **1.3.2 Aims of Phase 2**

1. To understand the ways in which GPs, nurse and pharmacist prescribers employ emotional labour within the context of a healthcare encounter
2. To identify the facilitators and barriers to the employment of positive emotional labour within healthcare encounters between patients, GPs, nurses and pharmacists
3. To understand how the sociological context (institution, gender, professional) influences the management of patients' emotional cues and concerns

## **1.4 Overview of Methodology**

It was considered that a single method approach would not sufficiently address the complexity of the research topic – comparing, identifying and understanding professional responses and ways of managing patients' cues and concerns. Phase one of the study lends itself to an approach to data analysis that enables the researcher to make comparisons about professionals' responses across the three groups using a larger data set. The qualitative phase, on the other hand, is suited to exploring how professionals manage patient's cues and concerns in more depth and is helpful in identifying the barriers and facilitators to the employment of emotional labour across the three professional groups since the analysis considers the wider context of emotion communication and management.

Both phases are underpinned by an interpretative epistemology informed by a method of inquiry which rejects claims to objectivity in the social sciences and science or positivism's 'irrational passion for a dispassionate reality' (Rieff, 1979). An interpretative epistemology acknowledges that people experience the world with both body and mind while challenging dominant claims to knowledge and supporting less privileged or subordinated voices (Kralik & van Loon, 2008).

Additionally, an interpretive epistemology makes explicit the researcher's role in the research process and 'value-laden nature of inquiry' (Denzin and Lincoln, 1998: 8). The two phases of this study lend themselves to an approach to 'knowing' which is informed by emotions and feelings in addition to cognitive aspects of knowing. I have utilised my feelings about the data which, according a number of authors, serve as a legitimate tool for understanding, analysing and interpreting the data. Given the focus of this study is exploring the ways in which patients' emotional cues and concerns are managed, it would seem epistemologically justified to utilise one's emotional sensing in this way (Ramazanolu, 2002; Hubbard et al., 2001).

With nurses and pharmacists new to the role of prescribing in primary care, this research has set out to broaden the application of emotional labour to the context of primary care, and specifically to widen our understanding of the ways in which other professional groups such as nurse and pharmacist prescribers and GPs manage patients' emotional cues and concerns within a healthcare encounter.

This study has employed two phases, using two different approaches to understand how patients' cues and concerns are managed. The first phase has employed a coding framework to ascertain the nature (content) of patients' cues and concerns, the nature of professionals' responses and to examine differences in responses across the three professional groups. Additionally, the first phase will examine whether factors such as the gender of the prescriber or consultation length will have a significant effect on professionals' responses. The first phase analyses the data quantitatively, employing both descriptive and inferential statistics.

The second phase has qualitatively analysed a sub-sample of transcribed consultations across the groups in order to explore how GPs, nurses and pharmacists employ positive emotional labour to manage patients' emotions. While phase one examines the cue-response sequence, the second phase explores the consultation process to understand how professionals use emotional labour to manage patients' emotional cues and concerns.

The study will also critically reflect on the value and limitations of employing a mixed method approach to explore this topic.

### **1.5 My Interest in the Topic**

My interest in this research topic, namely the communication of emotion stems from a longstanding interest in ways in which emotion is communicated within our society and the complex social and cultural norms and rules which govern how and what is expressed. By observing the relational process of emotion communication in others and myself, I have often been surprised at what is communicated and often what is not communicated. My observations about the way in which our society communicates and manages emotions is also informed by my experiences of living in other cultures whilst working as an English teacher for six years. My experiences of working in different countries such as Tanzania, China, Nepal and Portugal have perhaps provided me with a more critical understanding of my own culture. Furthermore, teaching English to foreign students both abroad and in the UK has also provided with observations derived from their insight into aspects of British culture. This experience has enabled me, to some extent, to take a more critical deconstructionist view of British culture and which also includes the communication of emotions and my observations of the way in which feeling rules can influence emotion communication and emotion work.

Furthermore, another key influence in my understanding of emotion communication derives from having undertaken initial training in

counselling and psychotherapy. In the early stages of undertaking my PhD, I undertook a one-year Foundation Course in Counselling and Psychotherapy which introduced me to the principles of person-centred therapy as advocated by the American psychologist/therapist, Carl Rogers. Carl Rogers advocated that for a successful therapeutic encounter to take place, the therapist needed to enact three core conditions: unconditional positive regard, congruence and empathy.

Whilst undertaking the foundation course, it was mandatory to undergo my own personal therapy which I undertook for a year. Whilst 'in-therapy', it was possible to understand how the enactment of Rogers' core conditions could lay the foundations for a therapeutic encounter in which I felt heard and understood. As I learnt to trust my therapist with my experiences and existential difficulties, fears and worries, it was possible to see the relational and therapeutic benefits of an empathic encounter in which I felt fully accepted and without judgement. For me, the experience of talking to someone who was understanding, non-judgemental and empathic was valuable.

The experience of having had my own positive therapeutic encounter has provided me with subjective evidence of the benefits of person centred approach and how having an empathic professional made me feel more understood and enabled me to trust myself or aspects of my selves to others. My experience reinforced the benefit and value of having one's concerns, ideas, fears and worries validated and understood when an individual is the recipient of an empathic encounter.

My own experience in therapy therefore gave me an insight into the potential benefits of empathy in any healthcare encounter, particularly when an individual is vulnerable, when faced with a serious or life-threatening diagnosis, illness or the challenges faced when managing a chronic health problem.

I am aware of the need to understand that each patient exists within their lifeworld, most of which may be unbeknown to their healthcare professional. The context of people's lives, their psychological, emotional, social and physical lives may not be evident but can all contribute to how

a person feels and how that may impact on their health and well-being. This highlights the importance of listening, understanding and acknowledging the context of patient's lives.

When listening to audio recordings in which patients tell their stories and express their emotional cues and concerns, I try to imagine myself into the lives of patients and ways in which patients' emotional expressions can provide a rich context for their lives beyond symptoms, diagnoses and treatment. I can empathise with the needs, demands and experiential worlds of patients and practitioners and yet as a lay person with no clinical background, it is the voice of patients that I identify more with.

I have also reflected on how my values and interests may have been influenced by the cultural, social and political world in which I inhabit or have been drawn to. I feel that my interest in this study is ignited by an interest in the patient perspective particularly in recognition of potential sociological factors which may intercede in the healthcare encounter. For example, I am interested in how factors such as power/status/knowledge may affect ways in which the patient and professional encounter may play out or how privileging knowledge or discourses may inhibit or prevent patients from expressing their ideas, concerns, fears, worries in the healthcare encounter or having those needs met.

Despite the myriad of self-interests, values and positions which may have potentially influenced the research process, I have endeavoured to reflect on these throughout the process of undertaking this research. The epistemological position of interpretivism allows for the possibility that the researcher's experiential, social, political and historical context will, to some extent, influence the research process. The nature of qualitative research accommodates the interpretative nature of our relationship to our social worlds and how we make sense of social reality and phenomena which includes the researcher's relationship to the data and the interpretive nature of the research process.

The notion that research and the researcher can be objective and rational is often associated with a positivist approach to research and one which may consequently marginalise or ignore the importance of the

researcher's emotions and feelings in the research process. Such an approach may also ignore the emotional labour employed by the researcher to manage emotions – their own and those of their participants and data. As a result, a positivist approach in which reason favours emotion, may 'define the space within which knowledge can be legitimately constructed' and so within this study, value is attached to emotional sensing as an epistemologically valid method of working with data (Harris and Huntington, 2000:133).

Researchers working within an interpretative epistemological framework, subscribe to the understanding that researchers are inevitably emotionally beings who are involved with their subject and that we cannot detach ourselves from the social worlds of which we are a part (Perry et al., 2004). It is argued that researchers are not disembodied or dispassionate observers who can bracket off their emotions and epistemological baggage (Gould & Nelson, 2005; Perry et al., 2004). On the contrary, a researcher's feelings and emotions can provide a useful source of insight into the research process. For instance, a researcher's emotions and experiences within the research process, including their emotional responses to the data, can serve as a legitimate tool for understanding, analysing and interpreting the data (Hubbard et al., 2001).

Within the spirit of these research traditions and other authors who have explicitly employed their emotions and experiences in the research process (e.g. Johnson, 2009, Cingerman, 2006; War, 2004), I too, have used my emotional and cognitive sensing alongside valid and insightful experiences, predominantly those involved in my counselling and psychotherapy training as powerful tools within the research process. Namely, these experiences and feelings have been utilised in developing the research questions, in collecting data, in analysing the data, in interpreting the data and writing up my thesis.

To address and increase the trustworthiness of the data and study findings, I have made explicit my own values in the research process and have explicated the systematic processes which took place to ensure the method of data collection and analysis is fully transparent.



## **1.6 Structure of the Thesis**

*Chapter 2* provides an overview of the literature relating to the wider context in which this study took place, namely the setting of general practice – and its workforce. The section provides an overview of how the extension of prescribing to other healthcare professionals has impacted on the changing roles and responsibilities in primary care. The following section discusses the introduction of pay-for-performance schemes in general practice and how this and other factors may influence approaches to working. The subsequent section outlines the rise of patient centred medicine and shift towards a more holistic model of medicine as encapsulated in the biopsychosocial model of health. The benefits of patient centred medicine and responding to patient's emotional cues and concerns are discussed in addition to the challenges of providing this approach in practice. This section also provides an overview on the literature relating to patient-professional communication and how this relates to decision making about medicines, particularly within a patient centred framework. I provide an overview of the literature on professionals' responses to patients' cues and concerns and methodological approaches to doing so.

The next section presents the key social theory employed in the qualitative phase of the study, namely Hochschild's emotion work theory and situates this within a sociology of emotion. This section discusses the social constructionist ontological underpinnings of emotion work theory while also considering the Marxist and feminist influences of emotion work theory and how these relate and apply to the healthcare setting. The introduction to this section explains why these theories provide a useful framework to understand why patients might employ cues (indirect expressions) to communicate emotions and more broadly in terms of the ways in which emotions or feelings are managed within a healthcare context. The following section presents the results of a systematic literature review of emotion work/emotional labour employed by healthcare professionals in a healthcare setting which include both intrapersonal and interpersonal aspects of emotion work. The review

identifies what work has been undertaken in this area, what methods have been employed to research emotion work within a healthcare context and, finally, the review identifies gaps in research undertaken, to date. These findings are subsequently reviewed in terms of their relevance and application to the aims and objectives of this research.

*Chapter 3* first provides a description and discussion of the methodology using a mixed methods approach. The first section provides an overview of the context in which this research took place and a discussion about the rationale for adopting a mixed method approach. The next section discusses the ontological and epistemological foundations which have guided the mixed method approach. The following section describes the method of data collection which includes a description of the recruitment process of study participants (patients and professionals) and study sites. The aims and objectives of phase one are followed by an in-depth discussion about the development of the coding framework for this phase. The next section provides a description of the analytic process, choice of statistical tests and a discussion about the credibility and validity issues related to the coding process and inter-coder reliability.

The following sections relate to the qualitative method employed in the study. The first section discusses the ontological and theoretical basis underpinning the analytic process and use of theories. The next section presents the aims and objectives of the qualitative phase followed by a description of the method of sampling and a detailed description of the coding process. The final section evaluates the analytical process which includes a discussion on issues around the researcher's relationship to the data and a reflexive examination of my interest in the study phenomena and other factors which may have influenced the process of data collection, analysis and interpretation.

*Chapter 4* presents the results of the quantitative analysis which includes descriptive statistics relating to participant and practice demographics and the type and length of consultations across the three groups. The following section presents frequencies showing the nature of patients' cues and concerns and the type of prescriber responses. The next section

will present the results of inferential statistics used to compare professionals' responses across the groups. The results of correlations to identify what demographic variables (age and gender of prescriber and consultation length) influence the type of prescriber response to patients' emotional cues and concerns are subsequently presented. The chapter concludes with a summary of the findings which relate to a published paper found in Appendix R.

*Chapter 5* presents the findings of the qualitative analysis of a sub-sample of thirty audio-recorded consultations and is presented in two parts. Both parts present and discuss the findings and their relevance to existing literature. Part one presents and discusses the range of skills and approaches utilised in the employment of positive emotional labour. Part two presents the barriers, challenges and constraints to employing positive emotional labour within the encounter. These have identified within three broad themes: (i) Emotional Disengagement – Keeping it Clinical (ii) Task Focused Consultations (iii) Structured/Agenda Driven Consultations

The final section concludes with an overview of the findings and interpretations derived from their relevance to the aims of this study, how they relate to the existing literature.

*Chapter 6* takes a personal perspective to reflect on the emotion work/emotional labour involved in various aspects of the research process, including the labour employed in collecting data and in data analysis. The following sections consider and reflect upon the study aims and research questions in turn. The first section summarises the findings from phase one and two to understand how healthcare professionals manage patients' cues and concerns. This section summarises the influence of sociological factors (gender and age of professional) and context (process demands on the consultation) on the way emotionality is managed within the consultation process. The next section reflects on the socio-cultural influences on the management of emotionality while the subsequent section reflects on the implications of the study findings on the training and support needs of healthcare professionals. The next

section provides an overview of the study methodology, in particular the advantages of employing a mixed-method approach and some of the limitations in doing so. In particular, this section discusses some of the epistemological challenges of researching emotions and empathy during the course of this study. These sections principally address the limitations identified in the data collection, coding and analytic stages of the study. The following section offers suggestions for future research while the final section considers the contributions and originality of this study.

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# Chapter 2: Literature Review

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## **2.0 Introduction: Scope of Review**

The literature review is presented in two parts, each comprising several sections:

Part one first provides a context for the study by giving an overview of the setting in which it took place – general practice and its workforce including the emergence of ‘new prescribers’ within this setting. This part goes on to introduce models and approaches to health care, particularly the rise of patient centred healthcare. Part one then focuses on how patients communicate emotionality in healthcare encounters and on healthcare professionals’ responses to patients’ cues and concerns. The key facilitators and barriers to delivering a more patient centred approach to health care are discussed in addition to methods for researching this topic.

Part two presents the theoretical basis for phase two of the study. The findings of a thematic literature review on emotional labour in a healthcare context are presented to identify the key findings to date and methods employed to research emotional labour within this context.

### **PART 1**

Part one begins by presenting a context for the study in terms of the setting; key changes in general practice and recent influences on the organisation and delivery of health care in this setting are discussed. Particular attention is paid to the introduction of pay-for-performance management schemes, namely the Quality Outcomes Framework (QOF) QOF, and its impact on patient centred care. An overview is provided of the general practice workforce, current demand for chronic disease management in primary care, the shifting roles and responsibilities of different healthcare professionals, and theoretical perspectives on the implications of this for the workforce and patients. Following this, an

overview is given of the introduction of 'new prescribers' into primary care.

The subsequent section discusses the ascent of patient centred healthcare. This provides a context and evidence base for the focus of the study and importance of responding to a patient's biopsychosocial cues and concerns in a healthcare consultation. The meaning of a patient centred approach is discussed, followed by an overview of patient centred care and its relevance to prescribing. An overview is then provided of empathy and its place in a patient centred approach to healthcare.

The next section discusses the communication skills training provided to undergraduate and postgraduate medics, nurses and pharmacists and specifically consultation skills incorporating a patient centred approach.

The following section discusses some of the challenges to delivering a more patient centred approach. This includes an overview of the literature on healthcare professionals' responses to patients' cues and concerns, and the barriers and facilitators to doing so. Part one concludes by discussing some of the methodological approaches which have been employed in researching this area and some of the challenges and opportunities which different methods present.

## **2.1 The Context of General Practice (Primary Care)**

This research is situated within the institutional setting of general practice and it is therefore important to provide an overview of this context, its workforce, the changing roles and responsibilities in primary care and the influence of political demands such as pay-for-performance schemes (e.g. the Quality Outcomes Framework) on the general practice workforce and approaches to working. The section will discuss the emergence of 'new prescribers' within the general practice workforce and ways in which this has influenced the organisation and delivery of care in general practice.

General practice was founded with the inception of the National Health Service (NHS) in 1948, with general practitioners remaining as independent contractors rather than as employees of the NHS. It has

been argued that by remaining as independent contractors, GPs have retained a degree of autonomy in the workplace and professional independence in their control over the recruitment, training and regulation of doctors (Friedson, 1970). However, the extent to which doctors have or continue to exercise their professional autonomy and power has been under debate (Elston, 1991) and will be discussed in subsequent sections.

In line with the underpinning values of the NHS, such as equity of access, general practice has been defined as:

*'The first point of medical contact within the healthcare system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex or any other characteristics of the person concerned'* (WONCA, 2005).

The Collings report (1950) found that general practice had poor standards of care and working conditions. A decade on, in the 1960s, general practice was required to sign up to contractual agreements with the NHS, which had implications for the way services were set up and delivered. Conditions and pay improved for GPs and practices were given additional resources to assist them in their role (for example support staff, better premises).

The 1970s saw the increasing professionalization of GPs with the establishment of the Royal College of General Practitioners (RCGP) in 1972, which provided GPs with a representative body for the first time. Three years later, doctors were required to undertake a 3 year mandatory post-graduate training programme in order to become GPs (King's Fund, 2011). An overview of the training requirements in relation to patient centred care and communication skills will be discussed further in section 2.3.

During the 1990s, general practice came under greater scrutiny from external management and the GP contractual arrangements reflected a shift in focus to evidence based medicine (King's Fund, 2011). The Darzi report recommended the use of quality indicators (Department of Health (DoH), 2008) and, in 2004, the shift to performance related pay with the

use of quality indicators saw the introduction of the quality outcomes framework. To meet the requirements of the QOF, practices are financially rewarded when they undertake regular medication reviews, blood pressure checks and relevant clinical tests for patients diagnosed with long-term health conditions (such as diabetes, hypertension or asthma). To be reimbursed, practices collect and record evidence of the reviews and tests which have been conducted on patients; this evidence is subsequently audited by the NHS before payments are made (NHS, 2013).

In 2014, changes were introduced to the QOF in terms of the way payments are made. Previously, points were awarded when specific reviews and outcomes had been met; more points resulted in higher payments. The new system has resulted in a reallocation of 341 performance related points to core funding and enhanced services (BMA, 2014). The amended system was not introduced at the time of carrying out the present study so has no influence on the findings but it is nevertheless important to highlight the introduction of such changes.

The QOF has been viewed as a controversial scheme by some (Doran et al., 2014). For instance, a systematic review assessing the impact of the QOF on the quality of primary medical care found that while the framework has had a varied impact on clinical outcomes and 'modest' improvements have been seen in the quality of care for patients with chronic health conditions, some concerns have been raised in relation to its impact on patient centred care (Chew-Graham et al., 2013; Gillam et al., 2012). Some authors argue, for example, that the process demands of the QOF have led to a tick box mentality and distracted health care professionals from delivering patient centred consultations and listening to patients' concerns (Gillam et al., 2012; Checkland et al., 2004).

Furthermore, Chew-Graham et al. (2013) undertook a longitudinal qualitative study which triangulated patient and professional data with recorded consultations to examine the extent to which the QOF influences routine review clinics carried out by doctors for patients with long-term conditions. The authors found that consultations are oriented along

biomedical lines in which doctors assume an expert position and patients become more passive and less likely to participate in the consultation process. The findings suggests that patients' agenda and concerns are often unvoiced and therefore unmet; patients become socialised into becoming passive subjects where their wider needs are overshadowed by the professionals' bio-medical agenda (Chew-Graham et al., 2013).

Although the authors frame their findings within the context of the QOF to determine its influence on the consultation process, these findings are not new and pre-date the introduction of the QOF. For instance, prior to the introduction of the QOF in 2004, other authors have similarly found that patients do not always actively participate in the consultation process, show passive deference to their health care professional (Stimson and Webb, 1976; Tuckett et al., 1985) and do not always voice their ideas, concerns and preferences to doctors (Barry et al., 2000). This persistence of asymmetry in the medical encounter, or variable participation in the consultation process, prior to QOF, casts doubt on Chew Graham et al. (2013) suggestion that the QOF is responsible for this approach. Perhaps the QOF is reinforcing pre-existing approaches to consultations and/or this may suggest other complex factors at play.

Furthermore, criticism of the QOF has been directed at the way in which patients with chronic diseases are being managed. It is argued that this approach is underpinned by the biomedical model due to pay-for-performance directives which require the supply of clinical indicators and measurements. Critics therefore argue that the QOF has eroded patient centred and holistic approaches which have long been the hallmark of primary care (Mangin and Troop, 2007). The same critics argue that this erosion of patient centred care also threatens the identity of general practice since patient centred care and holistic medicine have long been accepted as an approach in general practice when compared to the biomedical orientations of specialist medicine in hospitals (Checkland et al., 2008).

However, these claims to holism in general practice have been contested by authors who argue that commitment to patient centred care and the underpinning biopsychosocial model are more rhetoric than reality in that

there is a disconnection between what GPs say they do and what they do in reality (Checkland et al., 2008). Again this raises the question about whether the QOF can solely be blamed for the increase in process driven or biomedically oriented consultations. The rise of the biopsychosocial model and patient centred care, and evidence supporting this in practice, will be explored in more depth in subsequent sections of this chapter.

It is also argued that market forces operating in health care, epitomised by the QOF, coupled with the reconfiguration of the roles and responsibilities within the general practice workforce have, in part, contributed to the way in which care has become delegated and reduced to medical and process tasks. This approach has recently been described as the 'McDonaldisation' (Gillam and Siriwardena, 2011) of general practice in reference to the way patients are 'processed', being passed down a production line of workers who manage their care in turn. For example, the doctor diagnoses but the responsibility for managing chronic conditions such as diabetes is often handed over to nurses and, more recently, pharmacists, in some practices. It could be argued that medication reviews or chronic disease reviews (such as for asthma, diabetes or hypertension) are part of this process and that meeting the demands of the QOF could also lead to the objectification of patients. In this approach, patients may come to be regarded as a set of symptoms with various biomedical indicators/markers which need to be managed, rather than patients viewed as individuals with feelings who might prefer and benefit from being offered a more personalised and patient centred consultation (Gillam and Siriwardena, 2011).

Additional external demands, which may influence the consultation process and decision making around treatment, are local and national guidelines. For instance, local formularies or the National Institute for Health and Care Excellence (NICE) guidelines may, to some extent, influence decision making processes with regards to diagnosis and treatment, and therefore represent additional influences with which new and old prescribers may need to contend (Courtenay and Griffiths, 2004).

As well as these changes to process, the new millennium has witnessed a shift in the roles and responsibilities of general practice staff, particularly

nurses, as evidenced with the introduction of supplementary prescribing in 2004 and subsequently independent prescribing in 2006. The reconfiguration of general practice (and other health settings) and changing roles and responsibilities have resulted in a shift in professional specialisms and traditional hierarchies, as the following section will discuss.

### **2.1.1 The Primary Care Workforce**

General practice has witnessed significant changes in the roles and responsibilities undertaken by its workforce over the past 10 years. This has led to the reconfiguration of existing staff and the introduction of new health care professionals to primary care (such as pharmacist prescribers). It is argued that these alterations have resulted in changes to pre-existing hierarchies, which were based on professional status rather than professional ability and capability (Grant et al., 2008).

Commensurate with these changes and to meet patient demands and needs, the Crown report (DoH, 1989) recognised the need for a more flexible workforce. Following recommendations in the Crown Report, general practice saw a reconfiguration of the roles and responsibilities to manage increased demand and workforce shortages. These changing roles in general practice resulted in nurses assuming more responsibility for chronic disease management. These changes to nursing roles have seen an increase in the proportion of consultations carried out by nurses rise from 21% in 1995 to 35% in 2005 (Hippisley-Cox and Vinogradova, 2009). While nurses have assumed more responsibility for the management of chronic diseases and minor illness, highly trained nurses (for example, nurse consultants or nurse prescribers) have also specialised in specific clinical areas where responsibility is assumed for diagnosing patients and making treatment recommendations, including prescribing, with ongoing medicines or disease management (Nocon and Leese, 2004). General practitioners' roles have also changed with some doctors extending their skills and interests in education, management,

research, clinical governance, and responsibilities assumed by their participation in clinical commissioning groups or by specialisation in clinical practice, for example minor surgery (BMA, 2014; Nocon and Leese, 2004).

It is suggested that these shifting roles of different disciplines have been mediated by the rise of a consumerist movement and changing societal expectations and preferences for patient centred healthcare (Tuckett et al., 1985). It is argued that this shift from professional to patient centred care has also led to challenges to professional power (Nancarrow, 2003). Additionally, it is posited that the flux in professional boundaries has also been influenced by competitive market forces where roles are substituted and delegated to a less specialised and less highly paid workforce. This is evidenced by the introduction of healthcare assistants to undertake specific tasks requiring less expertise such as taking bloods (Nancarrow and Borthwick, 2005).

The changes in the healthcare workforce have received critical attention from varying theoretical perspectives. One theory which explicates changes in roles and responsibilities within primary care is the proletarianisation theory. The proletarianisation thesis argues that doctors are losing their autonomy and professional status due to the de-skilling of doctors and in their losing control over working conditions (McKinlay and Arches, 1985). In particular, recent concerns have been raised by the medical profession over their loss of professional identity and reputation as a result of the QOF. Critics of this system (mainly doctors) argue that in addition to the de-professionalisation of doctors, the QOF is placing the doctor-patient relationship, and doctors' professional integrity and values, at risk due to the demands of state-driven clinical priorities (Mangin and Troop, 2007).

It is argued that the introduction of prescribing could also be viewed as a threat to medical dominance due to post-professionalisation (Kritzer, 1999) and the loss of exclusive knowledge as 'non-medical' prescribers assumed responsibility, albeit limited to certain areas of clinical expertise (Britten, 2001).



However, counter arguments suggest that medical dominance remains supreme as doctors have largely managed to retain their power, status and higher earnings (Willis, 2006). Moreover, rather than becoming de-skilled, it is argued that doctors are re-skilling and specialising in specific clinical fields such as minor surgery (Nocon and Leese, 2004). It is therefore suggested that doctors subsequently retain their status through specialisation and by maintaining exclusivity over specific roles and by re-creating professional boundaries (Nancarrow and Borthwick, 2004).

The increasing demand in general practice is reflected by an increase in life expectancy and people living longer with chronic health conditions. It is estimated that by 2033, 3.2 million people will be aged over 85 years, compared with 600,000 in 1983 (Royal College of Physicians, 2010). People over 65 years visit their GP twice as frequently as individuals aged 15-44 years (Stationery Office, 1995). It is estimated that 65% of persons aged over 65 years are diagnosed with two or more chronic health problems (King's Fund, 2011). Currently, 90% of patient consultations take place in general practice yet the budget allocated to general practice accounts for only 8% of the total NHS budget (National Audit Office, 2007). Consequently, the pressure on primary care is currently at its highest and is predicted to increase in the future (King's Fund, 2011).

### **2.1.2 The 'New' Prescribers**

Significant changes to prescribing regulations were made following recommendations in the Crown report (DoH, 1989) to extend prescribing to district nurses and healthcare visitors. As a result of these recommendations, a national nursing formulary was introduced for district nurses and healthcare visitors (DoH, 1989), which permitted nursing professionals to prescribe autonomously (without authorisation from a doctor) from a limited formulary (list of medicines) including dressings, catheters and specific medicines. Subsequently, following recommendations in a second Crown report (DoH, 1999), supplementary

prescribing was introduced to nurses and pharmacists in 2003. Supplementary prescribing permitted the prescription of medicines from a limited formulary by nurses and pharmacists, following a diagnosis from a doctor, within a clinical management plan (CMP) similarly agreed by the doctor. Supplementary prescribing was extended to allied healthcare professionals such as physiotherapists, optometrists and radiographers in 2005 (DoH, 2005). A year later, in 2006, nurses and pharmacists were legally permitted to prescribe independently, following a completion of an approved independent prescribing training course, from a full formulary - with the exception of controlled and unlicensed drugs (DoH, 2006).

The rationale underpinning legislative changes to permit nurses and pharmacists to prescribe independently was principally related to maximising the skills and knowledge of highly trained healthcare professionals, which would increase the efficiency in the way patients were treated and managed (DoH, 2006). Independent prescribing would also contribute to more flexible team work across the NHS. Finally, extending prescribing would also increase access and choice (to treatments and professionals) to patients without compromising patient safety (Cooper et al., 2008, DoH, 2006).

Commensurate with the extension of prescribing, independent prescriber courses have incorporated communication skills modules which advocate patient centred approaches. In the training curricula, professionals are taught to consider and respond supportively to any concerns, worries and needs that patients may have in relation to their condition and/or treatment. In particular this involves exploring patients' worries, understanding the psychosocial impact of their illness and treatment on their everyday life, and providing empathy and support in response (von Fragstein et al., 2008; Silverman et al., 1998). The training of healthcare professionals is reviewed later on in this chapter alongside various communication models which have been employed.

Despite the importance of responding empathically to patients' cues and concerns and the clinical, emotional and relational benefits of doing so, it is still unclear whether this is being consistently practised amongst GPs, nurses and pharmacists (Greenhill et al., 2011; Yu and Kirk, 2008;

Zimmermann, 2007; McCabe, 2003; Barry et al., 2001; Reynolds and Scott, 2000; Levinson, 2000; Kleinman, 1988).

While the extension of prescribing has been widely welcomed by nurses, concern has been raised about the potential conflict arising from prescribing which predominantly relies on a biomedical model and those holistic values underpinning the training and practice of nurses (Cooper et al., 2008). Given the emphasis on the laboratory sciences and a biomedical model of disease in the training of pharmacists, there is a possibility that pharmacists may be insufficiently equipped to respond to patients' psychosocial concerns (Weiss et al., 2005).

With nurses and pharmacists new to the role of prescribing in primary care, this study was interested in exploring how nurses, pharmacists and GPs manage patients' cues and concerns within the consultation process. While nurses and GPs have played a longstanding role in providing and managing patients' health and treatment in primary care, pharmacists are relatively new to managing consultations with patients in this setting. Although newer to general practice, community pharmacists have had responsibility for decision making about minor ailments and making treatment recommendations for over-the-counter medicines.

Consequently, this study was interested in understanding more about the ways in which these three professional groups manage patients' cues and concerns within healthcare encounters in primary care and in identifying ways in which their management of emotionality (emotions/feelings) might differ. An overview of consultations skills training will be provided later on in this chapter. The following section will discuss the rise of patient centred medicine and the biopsychosocial model of health and its implications for health care, the consultation process and patient outcomes.

## **2.2 The Ascent of Patient Centred Medicine: From a Biomedical to Psychosocial Model of Health**

It has long been argued that a person's health should not merely be defined in terms of the absence of physical illness. The World Health Organisation (WHO) defined health as achieving the following:

*'To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities.'* WHO (1986).

This definition of health is embodied in the biopsychosocial model of health and associated discourse, which emerged in recognition of the complex interplay of the biological, psychological/emotional and social components of an individual's health and well-being. The WHO's original definition of health, dating back to 1948, reflects a discursive and philosophical shift towards valuing the psychosocial (personal, emotional, family, community) dimensions of an individual's health in addition to the biomedical components (Engel, 1977; Kleinman, 1998). Furthermore, proponents of the biopsychosocial model of health argue that adopting a more holistic approach to the individual's health in health care encounters, would lead to a more humanistic treatment of the individual; that an individual's feelings and emotional needs would be considered alongside biomedical/physical/clinical aspects of their health (Engel, 1977; Kleinman, 1998).

The paradigm shift was mirrored by recommendations and an increasing body of literature advocating a more holistic approach to medicine which recognised that health and illness could no longer be framed or explained in purely biological or physical terms. In response to the paradigm shift, policy makers and regulatory bodies in the UK, such as the Royal College of Nursing, the Royal Pharmaceutical Society and the General Medical

Council, endorsed a patient centred approach to healthcare consultations (General Pharmaceutical Council (GPhC), 2012; General Medical Council (GMC), 2009; Nursing and Midwifery Council (NMC), 2006; Hasman et al., 2006; DOH, 2004).

The biopsychosocial model and emerging discourse later became operationalised in healthcare consultations with 'person/patient centred medicine' whose approach was to place patients' needs (for example, their questions, ideas, concerns, requests, interests) or their narratives/stories at the centre of the consultation (Smith, 2002). Advocates of a person centred approach sought to broaden the focus of the consultation to include the patient's 'life-world' (Mishler, 1984) or patients' experience of their health, illness and treatment. They argued that this would confer both clinical and therapeutic benefits for patients and professionals (Stewart et al, 2000; Kleinman, 1998).

The shift in policy and discourse from doctor to patient centred medicine, recognised the importance of understanding the patient's life-world view in the consultation process in addition to understanding how the dynamic between health care professional and patient can influence the process and outcomes of the consultation. As Engel highlighted, it is as important for the patient to be understood as it is for the medical practitioner to understand:

*'To know and understand is obviously a dimension of being scientific. To be known and understood is a dimension of caring and being cared for'* (Engel, 1988: 124).

Despite the shift and endorsement of patient centred communication as an approach to delivering health care, criticism has been targeted at some of the underlying claims of patient centeredness as an approach to healthcare that is universally preferred by all patients. For example, in a meta-analysis of the effectiveness of interventions intended to improve patient centred communication, the authors (Dwamena et al., 2012) found that not all patients wished to have their psychosocial issues explored. Additionally, Dwamena et al., (2012) identified that not all patients desired information; and not all patients wished to share power

and make autonomous decisions. The authors also highlighted that these preferences were influenced by patient characteristics such as education background, ethnicity, age and gender. However, a more recent systematic review of patients' preferences for shared decision making suggests that, on the whole, patients prefer to discuss options and receive information from their healthcare professional (Chewning et al., 2011).

Despite the shift from doctor to patient centred care, the paradigm shift was received sceptically by critics of medical interventionism who argue that ascertaining a more holistic, biopsychosocial view of health and incorporating the patient's life-world view is an indication of the 'medical gaze' (Foucault, 1972) extending beyond biomedical concerns and into individuals' social and emotional worlds.

For example, Foucault may have questioned whether the medical profession has extended its gaze too far if they are in a position to be able to access aspects of an individual's personal life (Foucault, 1972). It also argued that with a recent focus on disease prevention in health policy and practice, healthcare professionals have had expectations placed upon them to seek information and provide advice about lifestyle behaviours such as drinking alcohol, smoking, diet and exercise. However, it has been suggested that this onus has placed some healthcare professionals in the role of 'moral entrepreneurs who are custodians and enforcers of mainstream societal moralities' (Baker et al., 1996: 78). The authors consequently argue that some patients may experience the medical gaze as morally judgemental if they feel their lifestyle choices under the scrutiny of health professionals. Criticism has similarly been directed at doctors as agents of social control in the way that doctors have enacted politicised health policies through the surveillance of individuals' lifestyle and victim blaming. It is argued that in medicalising individuals' lifestyle, it detracts or extricates the government from taking responsibility for the structural determinants of health (Navaroo, 1978).

However, the anti-medicalisation thesis has received criticism from some authors who question the underlying assumptions of the medicalization thesis that depicts patients or lay persons as inherently passive or docile. Williams and Calnan (1996) argue that patients are no longer passive

recipients of health care but are playing a more active and less assuming role in health care interactions and preferences for health care. This is reflected in more recent studies which suggest that patients, on the whole, prefer to be more involved in their care (Kim et al., 2004; Little et al., 2001) but that the onus is on healthcare professionals to provide space and opportunities to enable patients to express their needs, ideas and preferences (Mead and Bower, 2000). As a result, a balance needs to be reached in terms of respecting the individual needs and desires of each patient and their autonomy which, it may be argued, is a central tenet of a patient centred approach.

The previous section discussed the ascent and importance of adopting a biopsychosocial approach to the consultation and how this became operationalized within the patient centred model of care. An aspect of this paradigm shift emphasises the importance of responding to a patient's wider psychosocial world, their feelings, beliefs and expectations, in addition to their experience of health and illness. The following section will explore the meanings of a patient centred approach in more depth with a discussion of the associated skills required to deliver it. In particular, this section will discuss the importance of empathy and its role in a patient centred approach.

### **2.2.1 What is a Patient centred Approach?**

Terms such as a patient centred approach, patient centredness and patient centred communication are often used interchangeably. According to Epstein et al. (2005), the multiplicity of terms highlights the lack of clarity and disparities in defining and operationalizing the term patient centredness. Is patient centredness a model of care, a component of care or a philosophical approach to care? Epstein et al. (2005), argue for the latter, that patient centredness is a moral philosophy with the following three core values:

1. Considering the patients' needs, wants, perspectives and individual experiences

2. Offering patients opportunities to provide input into and participate in their care; and
3. Enhancing partnership and understanding in the patient-physician relationship

(Epstein et al., 2005:1517)

In order to provide clarity and operationalize the term 'patient centred approach' either as a model of care or moral philosophy, Mead and Bower (2000) undertook a literature review to identify the qualities of a patient centred approach. Mead and Bower identified 5 key dimensions of communicative skills, behaviour and attitude of professionals that promote a patient centred approach. The five dimensions are:

1. Biopsychosocial perspective – a perspective to healthcare which incorporates biological/clinical with psychological/emotional and social aspects of a person's life
2. The 'patient as person' – understanding and recognising the patient's experience of health and illness
3. Sharing power and responsibility – a more egalitarian/democratic approach to the professional-patient encounter
4. The therapeutic alliance – fostering a caring, sensitive and sympathetic manner in consultations
5. The doctor-as-person – recognition of the dynamic nature of the professional-patient relationship and therefore requires professionals to be self-reflective and self-aware

More recently and relatedly, Epstein and Street (2011) introduced the concept of shared-mind which they employed within the context of shared decision-making within the consultation. Skills, attitudes or approaches which promote shared mind echo those of patient centred approaches described previously. Communication that promotes shared mind as highlighted by the authors included attuning to the patient's world, characterised by mutual understanding, empathy and compassion and exploring emotions (Epstein and Street, 2011).



Despite the policy and practice drive towards patient centred approaches in healthcare, some criticism has been directed at the unrealistic assumptions about the extent to which this approach can be enacted in practice due to the inherent asymmetry in the doctor-patient relationship (Pilnick and Dingwall, 2011). These authors are critical of normative understandings of patient centred care and research which views asymmetry as problematic and explained within a discourse of medical dominance and oppression. In their analysis of interactions using conversational analysis, the authors argue that 'asymmetry lies at the heart of the medical enterprise: it is founded in what doctors are there for' (Pilnick and Dingwall, 2011: 1374). Consequently, they urge researchers to view patient centred approaches as interactions which are underpinned by respect for the patient rather than expectations that patients need to participate in the consultation process and that failure to do so is attributed to medical dominance.

However, these authors do not acknowledge the clinical and psychotherapeutic benefits attached to patient centred approaches which adopt a more holistic approach to patients' health and illness experience. Additionally, the authors fail to recognise that, on the whole, patients prefer to be more involved in decisions about their treatment and feel more satisfied when their ideas, concerns and expectations have been voiced and considered (Britten et al., 2000). Additionally, patients are more likely to follow a recommended course of treatment if they have been involved in the shared decision making process (Stevenson et al., 2000).

Different authors (Bensing, 2000) have highlighted other challenges to the enactment of patient centred medicine; namely the epistemological tensions in the differing paradigms underpinning evidence-based medicine and patient centred medicine. For instance, Bensing (2000) argues that evidence-based medicine is essentially a positivistic, biomedical perspective which relies on clinicians interpreting scientific evidence about the most appropriate form of treatment. It assumes a more paternalistic relationship where patients are not viewed as individuals with unique

needs and preferences. In contrast, patient centred medicine is a biopsychosocial perspective which accommodates individuals' needs and preferences and which considers the therapeutic relationship as key to facilitating patient centred process and outcomes. Bensing (2000) argues that the challenge for patient and clinician is in determining how to bridge these separate worlds. The author argues that evidence-based medicine needs to incorporate more patient centred approaches (e.g. involving patients' views in RCTs), while patient centred medicine needs a theory driven evidence base. Finally, it is argued that communication plays a key role in bridging this gap and that both patient and professional have a part to play in this process (Bensing, 2000).

Continuity in care is viewed as important for good patient outcomes, including patient satisfaction, improved health status and sustained patient-professional relationship with higher mutual trust. However, a study by Jabaaij et al. (2008) found that the familiarity between a patient and professional was not associated with increased biopsychosocial content during the consultation. In other words, patients who were more familiar with their healthcare professional did not necessarily communicate more biopsychosocial information during the consultation.

Jabaaji and colleagues (2008) identified that doctors were more likely to raise prior content or known information about the patients' biopsychosocial world, which may have acted as a mediating factor on patients' decision to communicate additional information. However, the authors did not explore nor provide an explanation for these findings. For instance, perhaps when patients feel that they are understood by their health care professional, they may feel less inclined to communicate their psychosocial needs. Consequently, further research would need to be undertaken in this area to understand if patients have unvoiced agendas/concerns in consultations with their healthcare professional.

An observational study of nursing staff working in a palliative care setting found that familiarity was not necessarily a facilitator of psychosocial support. The authors concluded that psychosocial support does not depend on the level of familiarity with a patient and is not dependent on the professional building a relationship with the patient. The

observational data suggests that psychosocial support can be offered opportunistically and spontaneously when nurses are attentive and attuned to patients' needs, irrespective of how familiar they are with their patients. Additionally, the authors found that nurse characteristics (education, years of experience, team allocation) had no influence on the likelihood of nurses offering psychosocial support (Hill et al., 2013).

These debates reveal the complexities and realities of delivering patient centred medicine in practice. It also highlights the challenges of researching this topic area and need for critical reflection concerning the spectrum of barriers and facilitators to employing a patient centred approach and managing patients' emotionality.

The following section provides an overview of interaction and participation in decision making about medicines, particularly within a patient centred framework. Given the focus of the study is on primary healthcare professionals who prescribe, it was deemed important to provide an overview of the literature on patient-professional interaction to highlight the barriers and facilitators to patient centred approaches within this process. This relates to the ways in which patients ideas, concerns and expectations are managed and considered within this process.

### **2.2.2 Patient Centredness and its Relevance to Prescribing**

Historically, a considerable number of studies focusing on participation and decision making processes with regards to prescribing have centred on the doctor-patient relationship. However, the implications of these findings may also be applicable to nurse and pharmacist prescribers and perhaps highlights some challenges and pitfalls which newer prescribers may also encounter.

The previous sections have highlighted the value of patient centred healthcare and the importance of the patient-professional relationship in ensuring it is enacted. The process of involving the patient and respecting their beliefs and preferences is equally applicable to decision making

about treatment. In line with patient centred care, the recognition of patients as equal partners in the consultation process, and specifically with regards to treatment, is known as shared decision making or concordance (Weiss and Britten, 2003). Concordance has been defined as a process in which the patient and doctor reach an informed agreement about a course of treatment. This process requires that 'doctors identify and understand patients' views and explain the importance of treatment, while patients gain an understanding of the consequences of keeping (or not keeping) to treatment' (Elwyn et al., 2003: 327).

Understanding patient perspectives and what they want from the consultation is key to delivering a concordant approach. For instance, evidence from a qualitative synthesis on lay perspectives of medicine taking suggests that patients are frequently ambivalent and have shown active resistance to taking prescribed medicines (Pound et al., 2005). Being prescribed medication can have a significant impact on a patient's identity and sense of autonomy; at worst resulting in a diminished identity which can impact on their psychosocial world (Pound et al., 2005; Britten, 2003). Evidence also suggests that patients do not always voice their concerns and preferences for treatment during the consultation process (Barry et al., 2000). Patients have also been found to withhold information when they feel they may be admonished for non-adherence or when patients fear sanctions for failure to follow regimens. This finding is particularly relevant for patients diagnosed with severe mental illness and who may face the threat of being sanctioned through sectioning, for example (Britten et al., 2009).

Furthermore, to compound these communication barriers or reasons for non-adherence, there is evidence to indicate that patients do not always feel able to communicate their beliefs, preferences and experiences about taking medicines. Reasons for this may come from consultations that are more doctor-centric, in which the doctor may dominate discussions about medicines; or consultations in which professionals block patients' concerns or fail to explore patient preferences (Stevenson et al., 2004). It has been argued that when patients are not involved, there is greater potential for misunderstandings to occur in relation to prescribing

decisions, which can include misunderstandings about information conveyed by both doctor and patient, disagreement about attribution of side effects or misunderstandings about diagnosis and treatment. This evidence therefore highlights the importance of open negotiation about medicine taking and the value of actively involving patients in decisions about treatment (Stevenson et al., 2004). Moreover, it highlights the value of inviting patients to communicate their feelings and concerns about their health and illness experience and treatment and the importance of following up on expressed cues and concerns (Barry et al., 2000). Furthermore, it has been found that patients value concordant consultations in which they feel comfortable and are encouraged to express their concerns and preferences (Stevenson et al., 2004).

Further evidence of miscommunication or misunderstanding pertains to doctors' and patients' expectations of a prescription and shows that patients may not be as prescription oriented as doctors believe (Stimson, 1976; Lado et al., 2008). In a study (Webb and Lloyd, 1994) utilising data derived from pre- and post-consultation questionnaires with patients and doctors, it was found that half of all patients anticipated a prescription for their presenting condition. The authors found that the doctor's decision to prescribe was influenced by patients' expectations of wanting their presenting problem managed and by a perceived need to have patients' anxiety allayed. However, patients' reported anxiety levels prior to the consultation were not associated with their expectations for a prescription (Webb and Lloyd, 1994).

Similarly, in a pre and post consultation questionnaire study by Britten and Ukoumunne (1997), while more than half (67%) of patients indicated that they were expecting a prescription, 44% of patients indicated that they were issued a prescription which they had not hoped for. The authors found that doctors' perceptions of patients' expectation to prescribe was the strongest predictor of doctors' decision to prescribe and not patients' self-reported expectation for a prescription. The doctor's decision was therefore influenced by a sense of pressure to prescribe which did not necessarily relate to patients' expectations for a prescription (Britten and Ukoumunne, 1997).

In studies which undertake a closer examination of doctor-patient interaction, it is revealed how the forms and conditions for patient participation are influenced by the way doctors present their rationale for their decision-making (Stevenson, 2005; Heritage and Stivers, 1999; Peräkylä, 1998). The authors identify that the way in which doctors communicate has implications for patient participation and acceptance of diagnostic and treatment decisions.

For instance, Peräkylä (1998) employed conversation analysis (CA) to examine 100 primary care consultations. In this study, she identified two formats which doctors employ for delivering a diagnosis. The first format involves an unaccompanied assertion of the diagnostic decision, while the second format uses a decision accompanied by an explicit reference to, or account of, the evidence on which the doctor makes his decision. Furthermore, Peräkylä (1998) identified that doctors are more likely to employ the second format when there is the possibility for disagreement and which either corrects or rejects the patient's diagnostic suggestion. While patients generally respond minimally to the first format, it was observed that patients frequently respond to the second format, often by describing additional symptoms. Peräkylä (1998) argues that the second format was shown to provide an opportunity for the patient to participate in the consultation by offering their response to the doctor's decision, enabling them to provide more information about their symptoms and their particular concerns. Doctors' approach to voicing decision making about a diagnosis or recommended treatment has similarly been highlighted as an important communicative feature in the concept of 'shared-mind', as discussed previously (Epstein and Street, 2011).

Heritage and Stivers (1999) also employed a CA methodology for analysing doctors' 'online commentary', which refers to the accompanying commentary doctors give when providing a rationale for their diagnostic decision. They observed that when doctors voice their evaluation of certain signs and symptoms when undertaking a physical examination of a patient, patients are more likely to accept the resulting diagnosis. Additionally, doctors were more likely to employ online commentary if they considered their patient might resist a diagnosis or where there may

be subsequent disagreement. Therefore the employment of accompanying evaluation talk appeared to serve as a device for pre-empting disagreement. Similarly, the same authors identified that when doctors employ a similar device, using online commentary/evaluation, whilst making a treatment recommendation, patients are more likely to accept the doctor's decision. The authors argued that this commentary and justification of the rationale for the decision can serve as a useful mechanism to deflect or address patients' expectations for a prescription (Heritage and Stivers, 1999). Although, the authors highlighted the value of health care professionals communicating their rationale for decisions to their patient, this needs to be tempered with evidence presented previously regarding doctors' misperceptions around patients' expectations for a prescription (Stimson, 1978; Webb and Lloyd, 1994; Lado et al., 2008).

The findings from Webb and Lloyd's (1994) study also suggests that the doctors may be influenced by patients' levels of anxiety rather than any explicit expectation for a prescription. This observation links in with more recent findings discussed later in this section, which reveal that patients and professionals manage a range of anxieties (existential, interactional and entitlement anxiety) within the consulting room. In the context of the previous findings, patients' existential anxieties relating to their condition/problem may influence healthcare professionals' existential anxieties relating to good clinical decision making (Fisher and Ereaut, 2012), such as their decision to prescribe.

Misunderstandings around the prescription have partly been attributed to poor shared decision making and assumptions made by the doctor on the value of the prescription. For instance, previous research has highlighted that the prescription has become a symbol of a healthcare professionals' care and concern and their willingness to help (Weiss and Fitzpatrick, 1997; Comaroff, 1976). Furthermore, the act of issuing the prescription can serve to maintain a relationship between the patient and healthcare professional (Harris, 1980).

However, evidence indicates that patients who receive a prescription are less satisfied with the communicative quality in the consultation process

compared with patients who did not receive a prescription (Wartman et al., 1981). The authors suggest that the prescription is often a poor substitute for meaningful interaction which is an attribute/skill valued by the patient. Over and above the act of issuing a prescription, patients value doctors who demonstrate patient centred qualities and behaviours such as being attuned, attentive and taking the time to listen to their patient and take their concerns seriously (Wartman et al., 1981). This study highlighted the value that patients place on the therapeutic relationship or 'doctor as drug' as Balint (1957) described in his recognition of the importance of the therapeutic value of meaningful interaction. In other words, patients appear to place value on the therapeutic relationship with their healthcare professional and the quality of that relationship rather than on clinical outcomes such as the issuing of the prescription.

The authors highlight the need for further exploration of the interplay between patients' and providers' expectations of the process and outcome of the consultation. These areas of further research have been addressed by later studies conducted by, for example, Barry et al. (2000) discussed herein.

While patient centredness and shared decision making or concordance is regarded as key to patient outcomes and increased satisfaction, it may nevertheless be constrained by a further factor – consultation length. The evidence on this topic is mixed; some studies have found that participatory consultation styles require longer consultations and that consultation length is a further predictor of positive patient outcomes (Freeman et al., 2002). Additionally, doctors with longer consultations prescribe less frequently, while length of consultation has been positively associated with a better recognition and exploration of patients' psychosocial problems (Howie et al., 1991).

However, more recent evidence contradicts these findings; for example, Levinson et al. (2000) found that consultations took less time when doctors responded to patients' cues and concerns. Moreover, additional evidence shows that when healthcare professionals do not interrupt or re-direct patients' agenda items at the start of the consultation, the



consultation takes less time (Marvel et al., 1999) or is only fractionally longer - by seven seconds on average (Weiss et al., 2013).

The following section continues the theme of patient centredness and its relationship with empathy. The meaning of empathy and how this enacted is also explored.

### **2.2.3 Empathy and Patient Centredness**

An early definition describes patient centredness as an empathic approach as one in which the 'physician tries to enter the world through the patient's eyes' (McWhinney, 1989). This explanation of patient centredness relates to the definition of empathy as employed by the person-centred psychologist and therapist Carl Rogers who defined empathy as:

*'...when the therapist is sensing the feelings and personal meanings which the client is experiencing in each moment, when he can perceive these from "inside," as they seem to the client, and when he can successfully communicate something of that understanding to his client' (Rogers, 1951: 61).'*

For an individual, in order to be able to understand their world from their viewpoint and being able to communicate that understanding back to them, Rogers argued that by simply acknowledging the experience of the individual, they are likely to feel more understood (Rogers, 1951). It is posited that empathy is not a unique skill but a process underpinned by a range of skills (depicted in figure 1), which includes communication skills such as active listening and personal attributes such as being non-judgemental (Kohner, 1999).

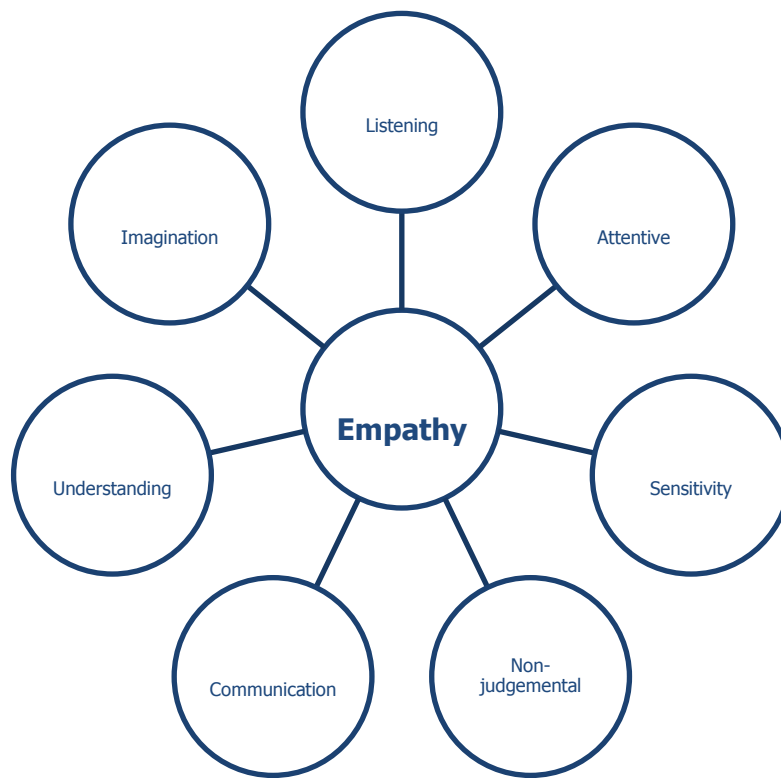


Figure 1: Skills for Empathic Communication (Adapted from Kohner, 1999)

In the field of person centred counselling and psychotherapy, it is argued that empathy is not characterised by a single response made by the counsellor to the client but is more accurately characterised as a process. Empathic responses are more of an indicator or a product of empathic process in which the practitioner is accompanying the client on their emotional journey (Mearns and Thorne, 2007). According to Mearns and Thorne (2007), research which aims to reduce empathy to single responses alone are overlooking empathy as a process. Mearns and Thorne argue that 'if research is to examine the process of empathy, then it must take into account, not only the verbal response of the client, but also the interaction sequence which has led up to that response and the shared understandings' (Mearns and Thorne, 2007: 70). They conclude that 'empathy is not a 'technique' of responding to the client but a way-of-being in relation to the client' (Mearns and Thorne, 2007: 34) and are therefore critical of communication skills training which reduces empathy to behavioural and formulaic responses.

These debates concerning the focus of empathy research have important implications for the focus of this study. The first phase of the study, the quantitative phase, is focused on the type of empathic response of the practitioner, while the qualitative phase focuses on empathy as a process of interaction sequences. This approach elaborates on the context in which cues and concerns are expressed and managed within the consultation. The latter phase is therefore more affiliated to the focus of empathy as a process, as advocated by Mearns and Thorne (2007).

According to person centred counselling and psychotherapy textbooks for trainee practitioners, empathy involves listening to the individuals' narrative but also listening to the emotions and feelings conveyed within the stories. Empathy also involves the counsellor learning to listen to her/himself to understand some of the deeper meanings which the client is conveying. Counsellors learn to trust their intuition, their thoughts, feelings, emotions, imagination and 'gut feelings' in sensing the meanings of their clients' feelings (Tolan, 2003). These debates and ways of thinking about empathy in the field of counselling and psychotherapy could be usefully transferred to the world of primary care and consultations between patients and healthcare professionals. Furthermore, the importance attached to counsellor/therapist's self-awareness in the therapeutic process and use of self to attune to the patient's world may have implications for the training of any professional who is required to be empathic in their work. Use of the self and trusting one's 'gut instinct' is also relevant for the use of emotional sensing researcher in the research process. This will be discussed at more length in the next chapter.

While Roger's core conditions and person centred approach has played an influential role in the training of counsellors, it has also provided a theoretical basis in the training of nurses (e.g. Bach and Grant, 2011). Despite the influence of Rogerian person centred therapy, it is not without its critics. Some authors argue that this approach adopts a very individualistic stand-point as expectations are on the individual to be enabled to utilise their own inner resources to find their own solutions, independent of potential socio-cultural, economic or environmental constraints. Critics argue this may place unrealistic expectations on the

individual to manage their psychosocial worlds irrespective of the constraints placed upon them. It is also argued that within a healthcare setting both nurses and patients are constrained by the limits of possibility about what can be realistically achieved in their consultation or interaction (Grant and Bach, 2011).

Consequently, this latter critique of person centredness highlights the importance of considering ways in which healthcare professionals manage patients' emotionality within a wider context. This context would consider the micro- and macro-level influences on the ways in which patients and professionals communicate and manage their emotionality. This highlights the value of adopting a social constructionist stance to view this process since it acknowledges the influence of social-cultural heuristics operating at a personal, organisational and societal level. Moreover, it recognises the possible constraints within which healthcare professionals operate.

The next section will present the evidence base supporting the psychotherapeutic and clinical benefits of employing an empathic and patient centred approach for both patients and professionals.

#### **2.2.4 Why is Empathy Important?**

It is argued that 'empathy underpins all communication and interpersonal skills and is at the heart of any successful, therapeutic relationship between a professional and a patient or client' (Kohner et al., 1999: 102). Furthermore, employing empathy in a healthcare encounter encourages the patient to express their concerns and to feel understood while enabling the doctor to learn more about the patients' lived experience (Bub, 2006). In addition, evidence suggests that healthcare professionals who respond empathically in the clinical encounter are more likely to feel satisfied in their work and are less likely to experience burnout and stress (Larson and Yao, 2005; Shanafelt, 2002).

Evidence also suggests that doctors who express empathy and respond positively to patients' emotional concerns during their consultations have

a positive influence on patient satisfaction, improve clinical outcomes and promote a better therapeutic relationship between professionals and their patients (Street et al., 2009; Oz, 2001; Levinson, 2000; Suchmann, 1997). Additionally, patients rate 'humanness' as an important quality in healthcare professionals (Kim et al., 2004; Little et al., 2001). Furthermore, having one's concerns validated and understood is 'intrinsically therapeutic; it bridges the isolation of illness' (Suchmann, 1997: 678). Indeed, adopting a patient centred approach is viewed by some as an ideology (Epstein et al., 2005) and, by others, as an ethical stance; that being patient centred is a moral imperative and is simply the 'right' thing to do (Duggan et al., 2006; Beauchamp and Childress, 2001).

### **2.3 What Communication Skills are Health Care Professionals Taught?**

The benefits and importance of patient centred or narrative based medicine have been endorsed within the literature, policy and educational curricula on healthcare communication (Hasman et al., 2006; DOH, 2004; Silverman et al., 1998) and as an approach to health care practice advocated by the principal professional governing bodies of doctors, nurses and pharmacists in the UK (GPhC, 2012; GMC, 2009; NMC, 2006).

In growing recognition of the importance of responding holistically, to patient's biopsychosocial needs, empathically, health care practitioners including nurses, doctors and pharmacists are taught communication skills which emphasise the importance of open questions, listening, empathy genuineness, and exploration of the psychological and social aspects of a patient's world (RCGP, 2012; NMC, 2006; Silverman, 1998).

The value of communication skills training is supported by increasing evidence to support its role in improving patient centred care and empathic communication (Propp et al., 2010). Communication skills training is aimed at developing specific skills; practitioners are taught to elicit and respond to patients' emotional cues and concerns in addition to their physical symptoms. For example, the Calgary-Cambridge guide, employed in the training of GPs and other health professionals, specifically

guides practitioners to pick up on verbal and non-verbal cues (body language, speech, facial expression, affect); and to clarify and acknowledge them as appropriate (Silverman et al., 1998).

The following section will provide an overview of the communication skills training that doctors, pharmacists and nurses receive. In particular, this section will highlight how training for doctors, in particular, has shifted from professional centred to more patient centred models of care.

In 2006, the Royal College of General Practitioners (RCGP) introduced its first curriculum which provided guidance on the competencies required of doctors to be general practitioners. Of the six core competencies, two require GPs to demonstrate patient centred care and holism in the consultation, which are defined as follows:

Patient centred care is defined as 'understanding and relating to the context of your patient as an individual and developing the ability to work in partnership' (RCGP, 2012: 14).

A holistic approach is defined as 'the ability to understand and respect the values, culture, family beliefs and structure, and understand the ways in which these will affect the experience and management of illness and health' (RCGP, 2012: 15).

To ensure doctors are fit for practice in these two competencies, they are assessed for their holistic practice and communication or consultations skills as part of their training. Historically, various consultation models may have been influential in the training of medics and it is important to briefly outline and reflect on the various models and their theoretical basis. The doctors in this study may have been taught consultation skills using different models which may have had an influence on the consultation skills they employ in their day-to-day practice.

The importance of communication skills can be traced back to the emergence of Balint groups (1957) which were devised in response to research undertaken by the Tavistock clinic in London. The groups included GPs and psychiatrists who met to discuss and reflect on the psychological aspects of patient consultations. As referred to previously,

Balint (1957) recognised the value of the therapeutic relationship and coined the phrase 'the doctor as drug' to acknowledge the importance and therapeutic value of the doctor-patient relationship and of taking a biographic approach to viewing the patient. Balint identified attentive listening and being able to relate to the patient as key skills needed to navigate the doctor-patient relationship.

The next consultation model emerged from analysis of observations derived from recorded consultations of doctors and patients (Byrne and Long, 1976). The authors identified that doctors tend to use a limited repertoire of consultation skills and that doctors who asked more questions had less repeat visits from their patients. They identified the following six consultation stages as key to a good consultation:

1. The doctor establishes a relationship with the patient
2. The doctor elicits the main reasons for the patients' visit, including their fears and concerns
3. The doctor takes a history which may include a physical examination
4. The doctor, in consultation with the patient, considers the condition
5. The doctors discusses possible treatment with the patient or further investigations are undertaken
6. The doctor closes the consultation

Another formative consultation model was developed by Pendleton (1984) who defined the consultation as the 'central act of medicine'. Like Balint, Pendleton recognised that the therapeutic relationship was of paramount importance. Pendleton's consultation model was developed from his analysis of observations taken from video recorded consultations. Pendleton developed a protocol for video recording consultations which respected the dignity of the patient and were sensitive to the professional-patient relationship. The use of such video recordings now forms the basis of reflective and formal assessment exercises used in the training of doctors and pharmacists. Pendleton's model was later adapted by Neighbour (2004), who identified the following seven stages, which incorporate a more patient centred approach to the consultation:

1. Elicit patients' reasons for attendance including their ideas, concerns and expectations and how the problem impacts/effects the individual. Ascertain if the patient has underlying fears or is looking for reassurance, or has any hidden agendas
2. Consider if there are any other continuing problems relating to their immediate health concerns or wider world (such as socio-economic conditions)
3. Choose an appropriate course of action. This may be a prescription, a follow up assessment/examination, or a therapeutic intervention such as reassuring the patient or providing empathy
4. Ensure patient and professional reach a shared understanding and that the patient understands the disease, aetiology and its treatment, or communicate the necessity of the patient needing to make lifestyle changes, for example, if a person is obese.
5. Involve the patient in decision making about ongoing management of their condition, which may include any discussion about alternative treatment or approaches.
6. Use resources appropriately – this may include decision making about which drug to prescribe or decision making around follow-up assessments
7. Establish or maintain a relationship – this is key to good medical practice

Pendleton (1984) also highlighted the following skills and behaviours required to enhance the doctor-patient relationship and facilitate a more equitable consultation which involves the patient in the consultation process: a welcoming approach; open questioning and the use of closed questions when required; attentive listening and maintaining eye contact; responses which clarify, summarise, reflect or convey empathy and understanding; explaining things in a language that the patient understands; closure, which may include recommending a course of treatment ensuring the patient has understood (Pendleton, 1984).

A subsequent model developed by Stewart and Roter (1997) incorporated the patient's agenda while integrating the clinical agenda into the consultation process. The authors advise that doctors gather information



using an illness framework, which pertains to the patient's agenda, and a disease framework, which relates to the doctor's agenda. These two frameworks are then brought together to provide a shared understanding which permits explanations, planning and decision-making.

A later model, and one which is widely employed in the training of doctors, nurses pharmacists, is the Calgary-Cambridge guide (Kurtz et al., 2003) and is a consultation approach derived from Pendleton's (1984) model discussed earlier. The consultation guide includes the following stages:

1. Initiating the session (rapport, reasons for consulting, establishing a shared agenda)
2. Information gathering (patient's story, open and closed questions, identifying verbal and non-verbal cues)
3. Building the relationship (developing rapport, recording notes, accepting the patient's views/feelings and demonstrating empathy and support)
4. Explanation and planning (giving accessible and comprehensible information and explanations)
5. Closing the session (summarising and clarifying the agreed plan)

Another consultation model emerged as a response to the recognition and importance of narrative-based medicine (Greenhalgh, 1998; Launer, 2002). This model proposed techniques to assist practitioners in understanding their patients' story which included the following:

1. Circular questioning or picking up patients' words to explore the patient's meaning by employing the patient's language
2. Importance of listening to the patient's story
3. Exploring the context of the problem which may relate to the patient's wider psychosocial world
4. Collaborating with the patient to develop a joint story (establishes equality in the patient-professional relationship) and assist in co-constructing if necessary
5. Shifting the balance of power to the patient

Patient centred medicine latterly emerged but similarly valued the importance of viewing the patient in their wider psychosocial context and recognised the need to acknowledge the patient's health and illness experience. Similar to Balint's (1957) and Pendleton's (1984) preceding models, patient centred medicine similarly recognised the value of the therapeutic relationship and recognition of the lived experience and embodied nature of health and illness (Stewart et al., 2003). This model or approach has been outlined in more detail in section 2.2.2.

These models reflect the shift from doctor to patient centred consultation models, in which the professional plays an active role in providing opportunities to involve the patient in the consultation process while taking account of the patient's ideas, concerns and expectations. Moreover, they recognise the complexity of health and illness and the importance of understanding the patient's health and illness experiences within the context of the psychosocial world.

The consultation approaches outlined above highlight the type of consultation skills required when working within a patient centred approach. This approach also requires the employment of emotional labour when, for example, involving the patient in the consultation process, attuning to the patient and exploring and responding to patients' health and illness experiences. It also places expectations and responsibilities upon the health care professional to facilitate and orchestrate a more patient centred approach – it does not happen naturally; patient participation requires an effort and investment on the practitioner's part.

This is supported in the findings of a systematic review by Beck et al., (2002) which sought to evaluate the doctors' type of verbal and non-verbal behaviour which determines positive patient outcomes, such as satisfaction. The authors of the review found that the following verbal behaviours and techniques resulted in positive outcomes for patients (such as increased satisfaction): empathy, reassurance and support, various patient centred questioning techniques, explanations, positive reinforcement, humour, psychosocial talk, information sharing, friendliness, courtesy, orienting the patient during examination (similar to

online commentaries discussed previously) and summarisation and clarification.,. Non-verbal factors which positively influenced patient outcomes included head nodding, forward lean, direct body orientation, and uncrossed legs and arms (Beck et al., 2002). These findings reveal the range of verbal and non-verbal communicative behaviours which influence the way patients feel about their consultation with their doctor. Additionally, these ways of communicating also influence clinical outcomes such as whether or not a patient follows their recommended course of treatment (Beck et al., 2002).

While communication skills and patient centred approaches are incorporated into the accreditation criteria for undergraduate pharmacists (GPhC, 2013), no specific models are advocated. Good communication is implied through a number of learning outcomes but is not necessarily underpinned by specific models. Therefore, there may be variability as to the type of consultation skills training employed across university settings. Similarly, on the independent pharmacist prescriber training course, good communication skills are incorporated into the learning outcomes but no specific guide is recommended.

For undergraduate nurses, communication and interpersonal training is a core part of the training curricula (McCabe, 2004) and is a NMC competency on which nurses are assessed (NMC, 2010). The NMC stipulates that:

'All nurses must use excellent communication and interpersonal skills. Their communications must always be safe, effective, compassionate and respectful...' (NMC, 2010:24)

It is argued that the nursing undergraduate curriculum is underpinned by a theoretical basis for its communication skills training. In addition, the curriculum debates some of the challenges of delivering person centred approaches in practice (Bach and Grant, 2011). For example, nurses are encouraged to self-reflect on the reality gap between what a nurse is taught and what is practised in a healthcare setting (Chant et al., 2002). Additionally, nurses are taught to be aware of the impact of the organisational settings and how social and cultural heuristics which

operate in a particular setting (such as a hospital ward) may influence approaches to care (Duncan-Grant, 2001). The recognition and awareness that organisations can act as social and psychological structures which can influence and be influenced by those working within it, provide nurses with a toolkit for self-reflective practice.

In relation to the training of empathy, nurses are taught to distinguish between their own emotions and those of their patients, and to maintain a separateness to enable them to employ a cognitive and emotional sense of the feelings of their patients (Bach and Grant, 2011). Nurses are also taught the value of trust, respect and attuning to their patients, conveying genuine interest, acceptance and caring. It is argued that in doing so, nurses are more likely to develop a secure emotional bond with their patients (Greenberg, 2007). Nurses are also taught that patients' concerns often remain hidden or undisclosed which makes empathic communication all the more challenging as nurses may need to attune to and explore patients' cues (Bach, 2004).

The emphasis on self-reflective practice and recognition of how a professional's feelings may intercede in the way they manage patients' emotionality is an important aspect of nurses' training. This recognition of the nurse-patient relationship as a dynamic encounter is key to understanding some of the challenges to employing positive emotional labour, as will be discussed later in this chapter.

As this section highlights, there may be a range of barriers and pitfalls when putting consultation skills into practice. Additionally, authors of one interpersonal and communication skills training manual (Bach and Grant, 2011) highlight that there are other discrepancies or challenges which may influence the enactment of consultation skills in practice. Practicing patient centred care is challenging on a busy ward, for instance, 'busyness' can sometimes be employed as a defence mechanism to avoid having to deal with patients' interpersonal and emotional needs. Similarly, task-oriented nursing can also act as a defence against anxiety as being occupied by a task enables the nurse to emotionally distance themselves from their patients and from emotionally demanding situations (Menzies Lyth, 1988).

The section has highlighted the realities of providing a patient centred approach in practice, which is open to a myriad of influences and constraints during patient-professional interaction and at organisational level. The following section will discuss factors which may impact on the quality of communication skills acquisition, which have namely been attributed to the assessment of quality in communication skills training.

Underpinning communication skills training is the recognition that effective communication skills are integral to maintaining effective relationships with patients and key to patient outcomes such as satisfaction, adherence, and recovery (McCabe, 2004). However, the quality of nurses' communication skills and effectiveness of communication training has received critical attention (Chant et al., 2002). While communication skills training has been regarded as valuable and is positively associated with skills acquisition and patient outcomes (Parry, 2008), the consistency and effectiveness of communication skills training has been brought into doubt due to the employment of unsuitable and inconsistent methodological approaches in evaluating communication skills training courses (Chant et al., 2002). Criticism of unsuitable methodologies namely refers to the absence of systematic, rigorous and suitable assessment procedures (Mullan and Kothe, 2010).

It is therefore argued that until such procedures are in place, and employed across training providers, there will be an absence of quality research to attest the effectiveness of communication skills training for student nurses. Critics argue that the suitability of communication skills training delivered to nurses to enable them to interact with patients within a patient centred approach, may be compromised (Chant et al., 2002).

The independent prescriber course for nurses includes consultations skills training based on models such as the Calgary-Cambridge guide, which is also employed in the training of pharmacist prescribers and GPs.

There is a range of evidence to support the clinical and psychotherapeutic benefits of using empathy and patient centred approaches within the consultation. However, what is actually known about what patients want and expect from their healthcare professional? Specifically, what do

patients want in terms of the approach and skills employed and exhibited by their health care professional? To explore this question, the following section presents an overview of the literature which reports patient preferences for consultation styles and skills.

### **2.3.1 What Consultation Styles or Skills do Patients Prefer?**

A recent literature review (Deledda et al., 2013) titled 'How patients want their doctors to communicate' reports the findings from both quantitative and qualitative studies which explore and synthesise patients' preferences for and expectations of communicative behaviours and attitudes in primary care doctors. From their synthesis of patients' preferences, the authors identified the following six themes which the medical consultation should try to accomplish:

1. Fostering the relationship
2. Gathering information
3. Providing information
4. Decision making
5. Enabling disease and treatment related behaviour
6. Responding to emotions

The latter of these categories, 'responding to emotions', includes the following communication and consultation skills: looking for clues, using intuition, exploring concerns, letting patients convey concerns, providing time and space within the consultation to enable patients to express their concerns, listening to the patient, not interrupting when the patient expresses concerns, using silence, providing reassurance and being empathic and assisting patients in managing emotional problems (Deledda et al., 2013).

Furthermore, a recent study by Mazzi et al. (2013) invited 'lay' persons (participants recruited in public spaces, not patients per se) to assess video recordings of doctor-patient interactions. In their assessment, patients were asked to assess the overall quality of communication using

a Likert satisfaction scale (i.e. 1= not at all satisfying; 10=very satisfying) and were later invited to assess four interaction segments in more detail. Firstly, the authors found high levels of internal consistency or similarity in the way lay participants assessed the quality of the doctor-patient interactions (high internal validity). Secondly, interactions in which the doctor expressed empathy and partnership/therapeutic alliance with the patient, were rated highly by the study participants. Conversely, those interactions in which doctors shut the patient down and reduced space or opportunities for the patients to express their concerns and worries, were rated lowest by the study participants Mazzi et al. (2013).

A similar study by Bensing et al. (2011) invited lay persons to devise 'tips' for doctors, on communication/consultation skills, following their observations and discussions of videotaped doctor-patient interactions. Participants' tips for doctors included the following empathic and patient centred approaches:

- Introduce yourself with unknown patients
- Show patients they are welcome
- Keep eye contact
- Listen, don't interrupt the patient
- Show compassion, be empathic
- Pay attention to psychosocial issues
- Take your time, don't hurry
- Treat patient's as human beings and not a bundle of symptoms
- Take the patient seriously
- Be honest without being rude
- Avoid jargon, check the patient understands
- Know your limits, know when you have to refer a patient
- Invest in a common agenda
- Avoid disturbances by computer or telephone

The studies by Mazzi et al. (2013), Deledda et al. (2013) and Bensing (2011) provide insight into patient/lay preferences for doctors' communication styles and consultation skills. It is interesting to note that these studies have invited preferences for communication styles/qualities

of doctors and therefore, it would be helpful to understand to what extent lay/patient preferences or expectations would vary with other types of professional groups.

The importance of exhibiting these skills and approaches to the consultation is also supported by patient satisfaction surveys which have found that patient satisfaction is positively associated with empathic and patient centred healthcare encounters while patients rate 'humanness' as an important quality in healthcare professionals (Kim et al., 2004; Little et al., 2001; Roter et al., 1987).

With evidence to support a patient centred and empathic communication style with particular emphasis on an empathic and patient centred response to patients' feelings, the following section will present an overview of the ways in which patients communicate their feelings, both directly and indirectly within a healthcare encounter.

## **2.4 How Do Patients Communicate Feelings in Healthcare Encounters?**

During a consultation with a healthcare professional, an individual may communicate direct or indirect emotional concerns which relate to their health and illness experience, treatment or wider psychosocial world (Zimmermann et al., 2007). Patients can often imply problems or concerns, which are referred to as cues, which can provide a clue or a window into the patient's emotional world (Levinson, 2000).

Although there is considerable heterogeneity and consequently lack of consistency in the terminology employed to explain this phenomenon, the terms cue, concern, clue, window of opportunity or empathic opportunities, refer generally to the utterance or expression of concerns about a patient's biopsychosocial world. These concerns can be expressed directly, indirectly or ambiguously. To provide clarity on how and what patients communicate, the following sections will provide examples from the literature on this particular phenomenon.



Some research suggests that the patients' stated reason for visiting may not necessarily be the one they initially present or communicate in the healthcare encounter. For example, patients may present with imprecise or 'medically unexplained symptoms' which may mask something more serious or stigmatising (such as depression), or a symptom or problem that may be potentially embarrassing to discuss such as bodily functions, sexual problems, stress, social isolation or mental health problems (Salmon et al., 2004; Barsky, 1981). Studies have also identified that patients may present 'tip of the ice-berg' symptoms (Gulbrandsen, 1998) which may cloak psychosocial concerns related to relationship problems, stress at work or existential concerns relating to having a sense of purpose or meaning in life or fear of death (Salmon, 2004; McWhinney, 1997).

Furthermore, for patients who are unwell or have been given a diagnosis, they may experience a range of feelings in response to their condition or treatment, which may include anger, disgust, relief, guilt, shame or sadness (Brown et al., 2003). Consequently, patients' emotional worlds and feelings are often complex and profound and yet can remain hidden or undisclosed to the healthcare professional. Patients' reluctance to disclose psychological distress has been partly attributed to the shame or stigma attached to mental health problems (Gask et al., 2003). Moreover, patients may withhold this information because they feel their psychological problems are better solved through non-medicalised sources such as talking to family or friends or seeking support through counsellors (Prior et al., 2003). In some instances, however, patients were found to prefer a medicalised explanation for their psychological distress as this legitimised their symptoms and absolved patients of the shame attached to having psychological problems or feeling or being perceived as 'mad' (Werner et al., 2004).

Evidence indicates that patients are sometimes reluctant to ask questions about a diagnosis or treatment to avoid challenging medical authority. As a result, patients are more likely to express related concerns indirectly, if at all (Heath, 1992; Beisecker, 1990).

Another consideration is the underlying fear and anxiety which patients bring to the consultation. Fear has been identified as a major factor affecting the practitioner-patient dynamic. For instance, Fischer and Ereaut (2012) identified three distinct fears which patients may bring into the consultation: existential anxiety (patients worry that they may have a serious illness or anxiety concerning their mortality); interaction anxiety (patients worry, either subconsciously or consciously, about what they will say to their doctor or if they will have the opportunity to ask questions or whether or not they will be taken seriously); entitlement anxiety (patients worry about whether they have a genuine reason for visiting and whether they will actually warrant the sick role, are deserving of an appointment for which they seek reassurance that they are not wasting the doctor's time).

The authors further highlight that doctors also experience similar types of anxiety but for different reasons: existential anxiety (when doctors fear that they may have missed a diagnosis or recommended the wrong treatment – this anxiety threatens the doctor's identity and integrity); interaction anxiety (fear of the demanding patient; worry about how to negotiate the consultation process and/or that patients' expectations may not be met); entitlement anxiety (are doctors entitled to refer or prescribe within guidelines).

This highlights the complexity of the dynamic relationship between patient and professional and shows that both may be experiencing differing feelings. It is likely that both patients and professionals will be managing those fears simultaneously (Fischer and Ereaut, 2012).

The results of quantitative studies which reported the type of cue/concern and their frequency indicate that patients express a range of cues and concerns. For example, in one study by Levinson et al. (2000) the most frequently occurring type of cue/concern related to feelings about a biomedical concern (for example, frustration, guilt, fear about chronic health condition), feelings related to ageing, stress (work, family and other global concerns) and feeling depressed.

In light of this evidence Lang et al. (2000) developed a useful taxonomy of the nature of patients' cues and concerns related to:

1. Expression of feelings (especially concern, fear or worry)
2. Attempts to understand or explain symptoms
3. Speech clues that underscore particular concerns of the patient
4. Personal stories which link the patient with medical conditions or risks
5. Behaviours suggestive of unresolved concerns or expectations (i.e. reluctance to accept recommendations, seeking second opinion, early return visit)

To explore and understand more about why patients might communicate their feelings indirectly, the next sections draw on themes of shame and stigma within a healthcare and wider context. The discussion draws on Goffman's (1959) theory on the Presentation of Self to understand why individuals present or manage their emotions - the ways in which patients and professionals present themselves may explain why patients might infer or conceal feelings and aspects of their psychosocial world within healthcare encounters.

#### **2.4.1 Why might patients infer emotions rather than communicate them directly? Theoretical Perspectives**

*'Emotion is a lived, interactional experience with traffic rules of interaction framing how it is expressed and shared' (Bolton, 2008: 18).*

Goffman (1959) contributed to the notion that there are cultural and societal 'traffic rules' for interaction when he coined the term 'interaction order'. The interaction order refers to the way in which social interaction, gestures, rituals, what is spoken/unspoken are largely influenced by cultural and societal rules. Goffman suggested that in social interaction, individuals 'perform' when presenting themselves or an image of themselves in order to maintain face in social encounters. To explicate his

theory, Goffman employed dramaturgical (theatrical) metaphor to explain the ways in which individuals strive to perform a particular character or *face* to their *audience* (interactants or conversants). Goffman argued that maintaining face is a necessary performance in order to avoid being discredited or shamed. Shame is experienced when a 'performance' is deemed unconvincing or when it fails to meet the approval of their audience Goffman (1959)

Goffman defined face as '*an image of self, delineated in terms of approved social attributes*' (Goffman, 1959: 13) with an unconvincing or discredited performance leading to a loss of face for the individual and consequential feelings of shame (Goffman, 1967). Goffman was particularly interested in how individuals manage their communicative interactions including expressions or gestures used to maintain face (Coupland and Gwyn, 2003). The image of self, including our emotionality, and the ways in which it is presented could therefore influence the ways in which feelings are communicated by both patient and professional. Moreover, patients experience embarrassment and anxiety about whether or not they have a legitimate reason for visiting the doctor, with some patients delaying a visit despite being genuinely unwell (Pattenden, 2002).

For many individuals, revealing personal information that could leave someone feeling emotionally vulnerable is, according to Pollock, 'particularly challenging outside of relations of established intimacy' (Pollock, 2007: 166). Stimson and Webb (1975) also suggest that patients fear losing control or losing 'face' and so resort to implying problems rather than being direct about them.

The reluctance to disclose information about one's emotional health or to reveal our vulnerabilities to those outside our trusted circle could be attributed to the fear of 'losing face' and motivated by an individual's motivation to avoid shame – to maintain a positive face and convincing self-image when interacting with others (Goffman, 1959). This may be particularly relevant for patients managing a chronic illness or stigmatised condition, such as depression, whose identity may be diminished or 'weakened' by the experience of living with a chronic or enduring health problem/condition/illness (Pollock, 2007).

To maintain face and avoid shame, patients employ various devices or acts to manage their emotions or to distance themselves from 'social/emotional incompetency' (Baker et al., 1996: 188). For example, patients have been shown to use laughter as a means of distancing themselves from potentially embarrassing or uncomfortable situations, for example, in discussion about personal lifestyles such as drinking alcohol or smoking (Gross and Stone, 1964).

Evidence suggests that the expectation to maintain or save face or perform in any given social situation can have negative consequences for the health of individuals. Withholding information about one's emotional world and not being able to communicate one's feelings can lead to a phenomenon known as *dramaturgical stress*. It is argued that dramaturgical stress and the effort of managing or manipulating one's emotions and not expressing how/what we feel can contribute to physical as well as emotional ill health (Freund, 1990).

Additionally, individuals may also face expectations or an 'obligation to recover' in their 'sick role' (Parsons, 1951) as evidenced in the recovery discourse which employs metaphors such as 'fight the disease' or 'battle it out'. With expectations to be strong and to recover, patients may feel inhibited in terms of what they feel they can and cannot express. In performing a credible role, patients may 'put on a brave face' and be 'fighting fit' rather than disclose how they actually feel and thereby revealing their vulnerabilities (Pollock, 2007). The reluctance or potential shame in revealing one's vulnerabilities highlights the need for a person-centred approach to the healthcare encounter. In providing space, opportunity and permission for the patient to communicate their concerns and feelings within the consultation process, it enables individuals to voice and share their experiences and be heard.

This section has explored the more complex reasons for patients' lack of participation in the consultation process and reasons why patients may be reluctant to voice their concerns. Patients are often portrayed as passive or deferential, and have been shown to go to great lengths to avoid disagreement or conflict (Kettunen et al., 2001). However, within the consultation, patients communicate their dissent or disagreement in more

subtle ways. For instance, the use of silence is employed when patients are in disagreement about diagnosis or treatment (Stimson and Webb, 1975; Strong, 1979). Furthermore, patients have eagerly voiced their disagreements or criticism of their doctor beyond the consultation room and show their dissatisfaction or disagreement through non-adherence or other forms of resistance such as modifying their regimen (Pound et al., 2005). While a patient centred approach to healthcare has been advocated by policy makers, professional governing bodies and healthcare professional educators alike, the extent to which it is consistently being practised across professional groups is unclear, as the next section will discuss.

## **2.5 What are the Challenges or Barriers to a Patient Centred or Empathic Approach?**

Despite the paradigm shift and subsequent evidence to support the benefits of patient centred medicine, it has been suggested that the repositioning of the patient's story *or* narrative in medical consultations, has long presented an 'epistemological challenge' to medical authority (Bury, 1991). In other words, patient *or* lay knowledge *or* the voice of the lifeworld can differ in meaning and significance to medical knowledge *or* the voice of medicine. If medical knowledge takes precedent over lay knowledge in the healthcare encounter, patients' health and illness experiences may not be fully accounted for in the consultation process and in healthcare decisions. The differing meanings or 'competing epistemologies' (Bury, 1991) of patients and professionals in medical consultations is not uncommon and has been reported across the medical professions in different disciplines. For example, in a qualitative study conducted by Pilgrim and Bentall (1999), it was reported that professionals (GPs and psychiatrists) and lay persons were found to differ significantly in their accounts or understanding of depression. In a medical consultation where knowledge hierarchy often favours that of the doctor, lay accounts or patient experiences may consequently be overlooked or ignored.

It is suggested that these competing accounts and the privileging of knowledge highlights the inherently hierarchical nature of the doctor-patient interaction (Schmid Mast et al., 2011). In other words, doctors' medical knowledge and reliance on the biomedical model, takes precedence over lay knowledge, experiences and feelings. This privileging of knowledge may point to the epistemological fragility of relying on rationalist or positivistic clinical knowledge alone and consequently highlights the importance of recognising, acknowledging and incorporating lay beliefs and experiences into the consultation process, as advocated by a patient centred approach to health care. In relying on a biomedical model alone, important information about the patients' wider, experiential world may be excluded from the consultation and decision making process.

Additionally, it is also argued that that doctor's monopoly over the construction and ownership of medical knowledge enables doctors to define need, demand and decisions about entitlement to healthcare and referrals (Johnson, 1972). Another potential barrier to offering a patient centred approach may lie in healthcare professionals' approaches to managing their emotions and those of their patients. Observations of medical students training in hospital settings has identified that doctors employ various strategies to distance themselves from emotional aspects of the consultation process as a way of managing their own emotions and anxiety (Kleinman, 1998; Baker et al., 1996). According to some authors, these distancing strategies are also reinforced by the ways in which doctors are socialised in medical school to adorn a 'cloak of competence' (Haas and Shaffir, 1987) and not reveal one's doubts and vulnerabilities – perhaps to present a convincing image and avoid the possibility of shame if one's face or self-image becomes discredited. It is also argued that an over-reliance on the biomedical model also enables doctors to avoid discussion about psychosocial concerns which may be anxiety provoking or challenging to manage (Baker et al., 1996). Furthermore, the culture of distancing and disengagement with one's feelings in medicine can set a precedent for how feelings are expressed within an institutional setting. For instance, in her observations of hospital ward nurses, Smith (2012) found that nurses' feelings were not always legitimised within the ward

because the 'feeling rules' had been set by the medical profession. For nurses whose feelings were not legitimised within the prevailing medical culture, the experience was anxiety provoking and stressful (Smith, 2012).

Evidence of emotional distancing may also be compounded by evidence of social distancing which may further serve to disconnect doctors from their patients. Johnson (1972) argued that medical hegemony – the power and dominance exercised through specialized knowledge and skills of doctors - has created a social distance between doctors and patients (Johnson, 1972).

An additional barrier or challenge to a patient centred approach and offer of empathy is a health care professionals' experience of stress and burnout. Evidence suggests that doctors and other healthcare professionals who experience stress and burnout are less likely to meet patients' clinical and psychosocial needs (Bruce et al., 2005; Arnetz, 2001). The incidence of stress and burnout has been associated with the changes in the organization, financing and delivery of care which have added to existing pressures and stressors of the day-to-day work of a GP (Arnetz, 2001). While the literature has reported high incidences in stress and burnout amongst nurses working in hospitals, there is a dearth of evidence specific to nurses in general practice and therefore it is difficult to make any reasonable comparisons. Similarly, there is no literature to date which reports evidence of stress and burnout in pharmacists working in the same setting.

These observations provide evidence of how socio-cultural feeling rules may influence the ways in which particular professions manage their emotionality and consequently that of their patients. The ways in which medical students are socialised, and perhaps the conscious and unconscious influence of feeling rules, may therefore represent a challenge to working within a patient centred framework. It would appear that there may also be a conflict between what some healthcare professionals ought to feel and what they can or are able to feel.



Despite the change in rhetoric and value placed on eliciting and understanding patients' psychosocial or lifeworld view, more recent evidence shows that the perspectives, beliefs and concerns of patients are not consistently and actively sought (Zimmermann, 2007; Barry et al., 2001; Levinson, 2000; Kleinmann, 1988). As Kleinmann suggests, the focus of the medical interview often lies in ascertaining information about patients' symptoms rather than their stories (Kleinmann, 1998).

A literature review of doctors' responses to patients' cues and concerns concluded that doctors largely missed patients' cues and concerns (Zimmermann, 2007). Missed cue recognition was identified when doctors ignored, discouraged, avoided, denied, terminated discussion or employed thoughtless humour in response to patients' cues. The authors of the review suggest that doctors do not always respond to, acknowledge or elicit further information about these cues or concerns appropriately because they perceive that they are ill equipped to address or manage patients' emotional concerns nor respond empathically (Zimmermann, 2007).

Studies have also shown that when a patient's lifeworld is blocked (for example by redirecting the consultation to a biomedical agenda or by interrupting the patient) or ignored in the consultation, health outcomes tend to be poorer (Barry et al., 2001). Barry et al.'s (2001) study, which employed discourse analysis of healthcare encounters between doctors and patients, supported the claim that incorporating patients' lifeworld concerns leads to better outcomes and a more humane treatment of the patient.

Additionally, Butalid et al. (2014) revealed a similar picture in terms of professionals' management of patients' psychosocial concerns over time in order to ascertain whether empathetic communication had improved over time and to what extent this communication skill had been influenced by the implementation of clinical guidelines. The authors undertook an observational study of changes in doctor-patient communication between 1977 and 2008, specifically focusing on the communication of psychosocial problems. The authors found that empathy decreased over time, which they attributed to doctors' focus on task-based

communication (asking questions, giving information and advice). The findings reveal the tensions in trying to find a balance between meeting the demands of evidence based approaches and guidelines which promote symptom exploration to formulate diagnosis and inform treatment decisions. The authors argue that this focus overshadows opportunities to explore the patient's wider health and illness experience and provide space for patients to communicate their emotions (Butalid et al., 2014).

To date, research on empathic communication and responses to patients' cues and concerns has predominantly focused on medical consultations with doctors. Less is known about nurses' responses to cues and concerns. Some evidence suggests that nurses offer more holistic, educative, informative, accessible and approachable consultations (Drennan et al., 2009; Horrocks et al., 2002; Luker at al., 1998). However, the evidence appears mixed - a systematic review of studies investigating empathy in nurses revealed inconsistencies in the empathy levels and measurements employed across the studies (Yu and Kirk, 2008). A study by Reynolds and Scott (2000) found that nurses did not display sufficient empathy in their relationship with patients, while McCabe (2004) found that nurses communicate well with their patients when adopting a patient centred approach. However, McCabe (2004) suggests that the relationship was compromised when nurses switched to being more task focused, when taking patients' blood pressure, for instance. Finally, evidence suggests that nurses do not consistently appreciate the importance of employing patient centred communication (Chant et al., 2002).

Similarly, in a separate study by Checkland (2004), doctors indicated that nurses were now undertaking more biomedical components of chronic disease management and tended to be more task focused in health care interactions, which could compromise patient centred care. Despite these concerns, the authors argue that there was a disconnect between doctors' actual practice and their rhetoric - that practice structures, consultations and perceived identities ran contrary to the patient centred approaches which doctors so espoused (Checkland, 2004). This reflects previous research undertaken by Calnan (1988) which found GPs were divided in

their commitment to a holistic model of health care; some GPs advocated holistic approaches while others preferred a more clinical approach despite RCGP rhetoric which has advocated use of the former (RCGP, 2006).

Moreover, observations of the nurse-patient interaction which pre-date the QOF found that nurses did not always employ a patient centred approach, as evidenced by their frequent interruptions and interest in pursuing their own agendas rather than engaging patients in meaningful discussions of patients' concerns (Kettunen et al., 2001). As with previous evidence concerning the extent to which doctors' approaches are being influenced by the QOF, it is worth highlighting that healthcare professionals' consultation skills cannot solely be attributed to the process demands of the QOF.

A qualitative study exploring the views of doctors in the management of menstrual disorders, found that doctors maintained their medical identity through the employment of a biomedical approach (O'Flynn and Britten, 2006). The authors argue that relying on biomedicine to exert their status as doctors, in order to distinguish them from non-medical professionals (such as nurses), prevented the delivery of shared decision making in the consultation process. Additionally, the reluctance to share power and responsibility was purported to curtail opportunities for shared decision making (O'Flynn and Britten, 2006). These studies indicate that despite a commitment to the rhetoric of patient centred care and holistic medicine, doctors' practice and concerns about their identity as doctors are curtailing opportunities to lead patient centred consultations and democratic decision making.

Given the emphasis on the laboratory sciences and a biomedical model of disease in the training of pharmacists, there is a possibility that pharmacists may be insufficiently equipped to respond to patients' psychosocial concerns (Weiss et al., 2005). A recent qualitative study of pharmacist-patient communication, using the Calgary-Cambridge guide as an analytic framework, found that pharmacists were not consistently using a patient centred approach which included the observation that they were not picking up on patients' cues. As a result the authors recommended that pharmacists needed to be provided with the skill set in their training

to enable them to adopt a more patient centred approach to consultations (Greenhill et al., 2011).

The reviewed literature provides evidence of the range of barriers to patient centred consultations in which patients are given insufficient space to voice their concerns or when their psychosocial problems are not responded to empathetically. The literature reveals the complexity of the topic at hand and shows that the lack of patient centred care cannot be attributed to one factor alone. Rather, it reveals how a range of external influences or process demands, socialisation processes, communication based training and inherent asymmetry in doctor-patient interactions presents health care professionals and patients with communication challenges.

In sum, in addition to equipping healthcare professionals with the necessary communication skills to enable them to deliver a more patient centred approach, there are other broader, ontological and epistemological challenges (e.g. what informs approaches to knowledge in the different professional groups?) to offering a patient centred approach and employing a biopsychosocial model in healthcare consultations.

The following section will review the key methodological approaches to researching healthcare professionals' responses to patients' emotional worlds. The aim of this section is to present an overview of the approaches as a context for the choice of approaches employed in this study.

## **2.6 An Overview of Methodological Approaches to Studying Professionals' Responses to Patients' Cues and Concerns**

The methodological approaches to exploring and understanding this study area can broadly be divided into quantitative and qualitative approaches. Studies vary in their focus on the study phenomena; some studies focusing specifically on cues/concerns (Levinson et al., 2000) with others focusing more broadly on empathic communication (e.g. Bylund and

Makoul, 2002). Quantitative approaches categorise the nature of patients' cues and concerns and professionals' responses into specific categories which are then analysed quantitatively. The following section will firstly review the different coding systems employed to measure healthcare professionals' responses to patients' emotionality.

A literature review undertaken by Zimmerman and Del Piccolo in 2007 identified a range of studies employing both quantitative and qualitative methods to analyse a range of healthcare professionals' responses to patients' cues and concerns. The search identified studies which were broadly grouped as quantitative or qualitative with sub-categories describing different methods employed within these methodological approaches to measure or describe the nature of patients' cues and concerns and healthcare professional responses. Firstly, the authors identified those studies employing quantitative approaches using observational studies which sought to identify associative variables, such as frequency of cues and concerns or correlation with other factors such as consultation length or specialism of doctor (i.e. primary care doctors or oncology consultants). Secondly, the reviewers identified those studies employing sequence analysis which focused on interactions which preceded and succeeded the cue/concern or doctor's response (Zimmermann and Del Piccolo, 2007).

In the process of identifying a coding framework for phase one in this study, it was important to identify those facets of a coding system which would meet the aims and objectives of the study. It was important to be coding the nature of patients' cues/concerns and the nature of professionals' response. Additionally, the coding framework needed to be able to make comparisons across the groups.

Those coding systems which focused broadly on communication behaviours and not specifically on professionals' responses to patients' cues and concerns were excluded. For example, the Roter Interaction Analysis System (RIAS) (Roter, 1993), which is employed to analyse doctor-patient communication, employs a rating system based on global categories which include information giving, question asking and counselling. It was considered that this framework was perhaps too broad

and not specifically focused on understanding professionals' responses to patients' cues and concerns.

A decade after RIAS, Bylund and Makoul (2002) developed the Empathic Communication Coding System (ECCS), a hierarchical coding system to identify 'patient-created empathic opportunities' and healthcare professionals' empathic communication. The coding system assessed doctors' responses on one of the six following levels: Level 0 (denial); level 1 (perfunctory recognition of patient perspective); level 2 (implicit recognition); level 3 (acknowledgement); level 4 (confirmation); and level 5 (explicit recognition).

The Levinson (2000) paper made comparisons between the responses of two groups of medical specialists (primary care doctors and surgeons). Adopting this framework for the coding of phase one data, would enable comparisons to be made with the original study. The Levinson coding system was adapted for use in its own data set but was based on a coding system originally devised by Suchman (1988) and later by Branch and Malik (1993). The authors divided doctors' responses into two broad categories termed missed opportunities and positive responses, and thereby assumed a normative understanding concerning how healthcare professionals respond to patients' cues and concerns. The study employed descriptive statistics to describe healthcare professionals' responses and frequency and nature of cue/concern utterance across the two groups.

The additional appeal of this method was in its simplicity, in that the method for distinguishing the nature of patients' and professionals' responses appeared uncomplicated. However, as will be discussed in Chapter 4, the reality of trying to operationalise and apply a coding system to a wide body of audio-recorded consultations proved more complex and challenging. Additionally, as will be discussed in the subsequent chapter, when operationalising the Levinson coding framework within this study, it quickly became apparent that this method had its limitations in identifying the complexity of this study phenomenon (managing patients' cues/concerns). This limitation informed the decision to employ a second qualitative phase to undertake a more in-depth

analysis of the consultation process in order to examine the facilitators and barriers to the employment of positive emotional labour.

A year after starting this research, a new coding system, titled the Verona coding definitions of emotional sequences to code health providers' responses to patient cues and concerns (VR-CoDES-P), was developed (Del Piccolo et al., 2011). This 'neutral' (no value judgement concerning professionals' responses as right/wrong, appropriate/inappropriate), descriptive, detailed classification system emerged as a response to the methodological inconsistencies employed in researching this topic, as highlighted previously (Zimmermann et al., 2007). The coding system employs terms such as explicit or non-explicit response and identifies other responses which may facilitate further disclosure of a particular concern. The authors use categories such as providing/reducing space and sub-categories within these to describe the professionals' responses and their relation to the patients' subsequent utterance, for example whether a response reduces space and blocks further disclosure or whether it creates space by being explorative. This coding system offers a theoretically informed framework for describing the management of patients' emotionality by healthcare providers and perhaps offers a more explicit and robust methodology for future research in this area.

The Zimmermann and Piccolo (2007) review also identified qualitative studies which varied in their approaches, some of which employed conversation analysis to understand the interaction sequences at a micro-level. Proponents (such as Ruusuvuori, 2007; Collins et al., 2007; Drew and Heritage, 1992) of conversation analysis (CA) argue that it is a useful technique for studying interactants' talk in fine detail. CA has been employed within this area to identify the interactional features or behaviours which enable patient participation in healthcare encounters, as situated within a broader context of patient centredness. For example, a study by Collins (2005), which analysed audio-recorded consultations between nurses and doctors and their patients, found that doctors' talk tended to distance themselves from their patients while nurses' talk was characterised by closeness and connectedness.

Another study employing CA identified 'interactional motifs' (Chatwin et al., 2007: 85) such as rapport and mutuality which characterised more holistic encounters in allopathic consultations. The authors of the study defined mutuality as 'a form of equality which is manifest in interactions by, for example, a greeting which positions both participants similarly' (Chatwin et al., 2007: 90). Facilitators of mutuality include the use of introductory social conventions, employed to establish each other's well-being and which therefore bridge informal-formal conventions (i.e. how are you: I'm fine thanks: how are you), and use of naming (introductions, dialogue about preferences for naming). Chatwin et al. also identified features of rapport building such as small talk, familiarity (as distinct from over familiarity), humorous asides and collusive follow up or receptiveness to humour, which indicate mutual participation and equality in rapport building activities (Chatwin et al., 2007).

The contribution of CA, and its approach to analysing interactions sequentially, is its value in studying interactions in fine detail which take account of the broader context of the encounter. For example Peräklä and Ruusuvuori (2007) identified emotional reciprocity as an important component of patient participation. The authors define this component as patients' opportunities for expressing emotions during the consultation and healthcare professionals' responses to these displays. They suggest that behavioural repertoires (identified in other studies discussed previously) which enable participation include, for example, side conversations which are characterised by informal conversations or chats which veer from the tasks or question-answer formats and which maintain the patient-professional relationship (Jones and Collins, 2007) – similar to those rapport building activities identified by Chatwin et al. (2007).

Employing CA as a methodology for understanding talk in interaction, and specifically components of emotion participation, has influenced the approach to undertaking the qualitative analysis of consultations for this study. Specifically, this study has adopted the use of sequential analysis, which considers the wider context of the consultation and acknowledges and takes account of the health care encounter as a dynamic, collaborative interaction. Furthermore, CA methodology has also



highlighted the value of providing detailed descriptive accounts of case studies to identify the barriers and facilitators to positive emotional labour. CA provides a robust method for analysing conversational interaction yet may overlook macro level factors which may influence the consultation process and therefore it is useful to combine additional perspectives to understand other influencing factors. As a result, this study employed emotion work theory underpinned by social theory to understand other potential influences on the ways emotionality is managed within the healthcare encounter.

While a conversation analytic approach focuses on the fine detail of conversational interaction, other approaches to analysing language, such as discourse analysis focus on understanding how meanings are constructed and mediated through language.

The focus of discourse analysis is on examining the role that language plays in describing or constructing individuals' experiences or social reality and therefore examines and deconstructs the healthcare encounter from a more critical viewpoint compared to conversation analysis (Jorgensen and Phillips, 2002). Critical discourse analysis, for instance, would consider the interplay of macro level influences, such as the power and status of the professional group, on the dynamic of the health care encounter.

A study by Barry et al. (2000) employed discourse analysis to critically review the consultations of doctors and their patients. Barry et al. (2000) adapted Mishler's (1984) voice of medicine and lifeworld constructs based on his analysis of transcriptions of recorded medical consultations. Barry et al. identified four principal voices (two more than Mishler) which reoccur within doctor-patient consultations and may suggest a more dynamic use of discourse than Mishler had identified. The four voices are:

1. Strictly medicine - when patient and doctor use voice of medicine exclusively (physical complaints)
2. Mutual lifeworld - when doctor and patient are mutually engaged in lifeworld concerns (physical and psychological complaints)
3. Lifeworld ignored – when the voice of the lifeworld is ignored

#### 4. Lifeworld blocked – when the voice of the lifeworld is blocked by voice of medicine (chronic physical complaints)

The findings suggest that patients and doctors employ a range of voices/discourses which perhaps reflect the dynamic nature of the way in which interactants switch voices within the context of a health care consultation. This reflects the position of discourse theorists such as discursive psychologists who hold that we are relational beings and that in our interaction with others, language and meanings are co-constructed (Bryman, 2012). It is argued that the self is not 'an isolated, autonomous entity but, rather, is in dynamic interaction with the social world' (Jorgensen and Phillips, 2002:108).

However, within this dynamic, it is also important to acknowledge that potential power imbalances associated with differences in status and access to medical knowledge may (inadvertently/unconsciously) place pressure on patients to assimilate and employ medical discourse during the medical encounter. Whether conscious or not, medical discourse may be assimilated by patients in order to be heard - to *protoprofessionalise as* De Swaan conceptualised (1990). Similarly, Barry et al.'s (2001) study suggests that patients may employ the voice of medicine for different reasons. For example, patients may be using the voice of medicine strategically in order to obtain the best outcome for them since they may be aware of the limited value of employing the voice of the lifeworld in a medical encounter or/and there may be fewer opportunities to employ the voice of the lifeworld during the consultation. Additionally, there may be fewer opportunities for patients to participate or communicate their health and illness experiences due to the way the consultation is structured. Consequently, this may present an additional barrier to patients to express themselves (Barry et al., 2001)

Using a theoretical framework such as Barry et al.'s is advantageous in that it provides a way of testing and/or adding to existing theories whilst also providing a sound base from which to analyse or deconstruct the interactions and responses of professionals to patients' lifeworld. In reviewing the studies and methodologies employed by the various studies

in the literature review, it was evident that many studies lacked a theoretical basis from which to explore the study phenomena – namely the ways in which patients and professionals communicate and manage expressions of feelings within the health care encounter. Furthermore, research in this field, particularly within a primary care setting, has tended to focus on doctors and thereby overlook the communication skills of nurses and pharmacists. As a result, this study aims to address this gap by focusing on nurse and pharmacist prescribers' management of patients' cues and concerns.

Phase one employs a coding framework informed by previous research within this area to examine GP, nurse and pharmacist responses to patient's emotional cues and concerns. Phase 2 draws upon several research traditions within the field of medical sociology, particularly consultations analysed from a social constructionist framework, to understand the facilitators and barriers of emotional labour in context. The analysis will draw on analytical approaches which have provided detailed contextual descriptions of the health care encounters, for example analysis of transcripts focusing on the management of emotionality during the consultation process.

Phase 2 of this study draws on emotional labour theory in order to understand the ways in which patients communicate their feelings and how professionals manage these. Emotional labour, a theory originally conceptualised by Hochschild (1979, 1983), critically analyses emotion management within an organisational setting and recognises the social constructionist elements to emotional expressivity. Hochschild's theory drew on Marxist and feminist theories to understand potential influences on emotional labour within an organisational setting, which will be discussed in the following section. Drawing on these theoretical traditions and a social constructionist ontology, provides a useful framework for understanding the micro and more macro level facilitators and barriers to the employment of emotional labour by GPs, nurse and pharmacist prescribers.

## **2.7 Part 2 - A Sociology of Emotions**

This section sets out a sociological approach for understanding emotional expressivity and emotion management in healthcare encounters. The theoretical framework for phase two of this Research - emotional labour theory - will be presented and discussed in addition to the findings of a systematic literature review whose focus was on identifying emotional labour/emotional labour employed by healthcare professionals in a healthcare setting. The review discusses the key findings from this systematic review and gaps in the literature, to date and how this relates to the choice of method, and analytic approach to this study.

### **2.7.1 An Ontological Account of Emotional Labour Theory**

This study has adopted a sociological approach to the study of emotions which recognises the biological or physiological components to emotion yet considers the way in which meaning is imbued in emotions. This line of argument suggests that how we understand or interpret emotions in ourselves and others are largely mediated through social, cultural and relational practices. Figure 3 presents a model depicting a sociological perspective of emotions which incorporates social constructionist elements when viewing how embodied emotions (physiological/somatic reactions) come to be enacted, expressed, communicated or interpreted by the individual. In addition, although not a focus of this study, it recognises the role of the unconscious and its part in emotion management- an aspect of emotion theory often overlooked in Hochschild's account (Theodosius, 2008).

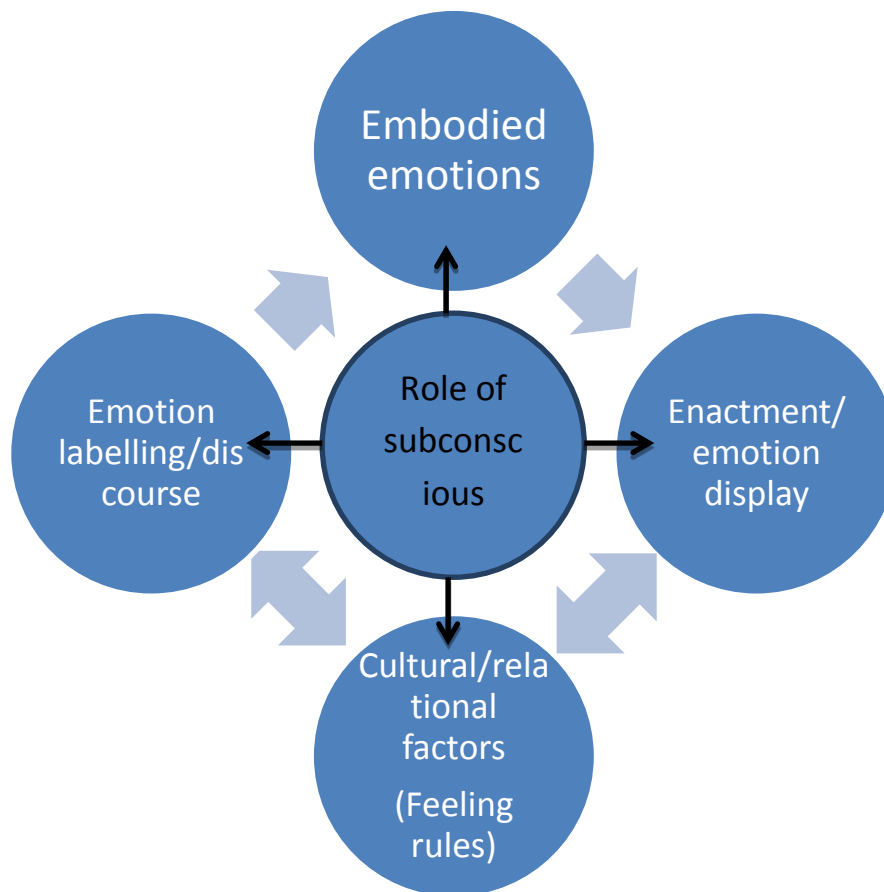


Figure 2: A sociological model of emotion communication

This social constructionist understanding of emotions underpins the principal theoretical underpinning of this research. Hochschild, the main proponent of emotional labour theory, recognises this complex interplay of the socio-cultural influences on how emotions/feelings are embodied, understood and communicated. Hochschild did not reject the intrinsic nature of emotions but rather recognised how culture impinges on how we come to assess, label and manage emotions (Hochschild, 1983). This model of emotion primarily refers to the way in which 'conscious' embodied emotions become enacted and shaped within a socio-cultural framework. In addition to this understanding of emotion, this model also recognises the role of unconscious emotions in any given relational dynamic (Theodosius, 2008). Although the study methodology does not

reliably enable these unconscious and hidden aspects of emotions to be identified, it is nevertheless important to acknowledge their potential role.

### **2.7.2 Theory of Emotional Labour**

Emotional labour is defined as the effort we invest in managing our own emotions and those of others (Hochschild, 1983). Hochschild developed Goffman's work in the field of performance management in the presentation of self by focusing specifically on emotion management or emotional performance in paid workers. Whereas Goffman focuses on the way we manage our outward performances through ritual, gestures and props, Hochschild turned her attention to the way in which individuals manage both their inner and outward feelings. In her theory, she defined emotional labour as: 'the act of evoking or shaping, as well as suppressing a feeling in oneself' (Hochschild, 1979: 266) in response to socially constructed heuristics or 'feeling rules' which govern what feelings or emotions can be felt or displayed in any given social context. In this way, Hochschild's theory focused on the way our outward appearances are managed internally in addition to the way our emotions are managed externally within institutional settings and private spaces (Hochschild, 1983).

Within the context of the workplace, Hochschild distinguished emotional labour from 'emotion work' to indicate how individuals or employees are engaged in emotional labour when employees 'regulate their emotional display in an attempt to meet organisationally-based expectations specific to their roles' (Brotherridge and Lee, 2003: 365). An important distinction between emotion work and emotional labour is that emotional labour refers to paid work whereas emotion work refers to private feelings. The concept of emotional labour recognises the effortful nature of this type of work, not dissimilar to the way in which physical labour places demands on the body. Hochschild drew on Marxist theory and argued that the organisational demands of the service industry or public sector expect workers to manipulate their emotions in order to meet their demands and expectations for engaging with customers or the public (Williams, 2012).

This theory of emotional labour emerged through Hochschild's observation of air stewardesses during which she observed that individuals engage in 'emotional labour' by presenting emotions that they did not always feel. According to Hochschild, individuals employ strategies for displaying 'appropriate' demeanours by, for example, altering their physiology (deep breathing, self-talk) or by manipulating their outward behaviour in 'surface-acting' in order to present their self in a socially acceptable or desirable way (Hochschild, 1983).

In the case of health care professionals, Hochschild argues that emotional labour is an expected part of the performance yet the extent to which performances appear convincing or genuine can vary depending on the level of engagement in emotional labour in what Hochschild referred to as 'surface' or 'deep' acting. Hochschild defined surface level acting as a superficial engagement which takes the form of smiles or gestures but which do not reflect our inner feelings. Deep level acting, on the other hand, refers to the outward expressions which are also reflected in the management of inner feelings. According to Hochschild, it can be stressful for actors engaged in surface acting in the staging and management of emotional labour due to the considerable effort required in acting out the performance (Hochschild, 1983).

According to Hochschild, the cost to the individual of meeting institutional demands in respect of emotion work is the way in which it 'affects the degree to which we listen to feelings and sometimes our very capacity to feel' (Hochschild, 1983: 21). It has been argued that the resulting stress in having to act in ways we do not feel manifests in a phenomena termed cognitive dissonance which relates to conflicting beliefs, attitudes or behaviours within ourselves (Festinger, 1957) and is not too dissimilar to the concept of dramaturgical stress posited by Freund (1990), discussed earlier. Cognitive dissonance has been identified as a major contributing factor in burnout and stress experienced by healthcare professionals who continually manipulate their emotions and perform in ways which do not reflect how they actually feel (Zapf and Holz, 2006).

Hochschild suggested that in this way emotions are managed and that, when 'on stage' performing, we do not always show what we feel or feel

what we show and consequently engage in emotional labour in order to present a socially acceptable or expected self-image, as in the example of air stewards in the service industry (Hochschild, 1979, 1983).

The application and relevance of Hochschild's original theory within a healthcare context will be discussed in the literature review. However, those key points of departure from Hochschild's approach which have primarily resulted from the application of Emotional Labour theory within a healthcare setting are summarised and set out by Theodosius (2008), below. Theodosius differentiates an applied approach to emotional labour theory within a healthcare setting in the following ways:

1. Emotional labour is integrated into nursing care; it is not a separate entity
2. Emotional labour is a collaborative therapeutic effort involving nurse and patients in a relationship; it is interactive and relational rather than merely performative; and this relationship is to some extent mutually beneficial – nurses care and help heal while patients' gratitude serves to sustain the care worker
3. Emotional labour is needed by patients because they are vulnerable; power relations between an anxious patient and nurse are vastly different from those between customer and flight attendant
4. Emotional labour involves an exchange of 'genuine' emotions going beyond emotional displays and feeling rules

(Theodosius, 2008)

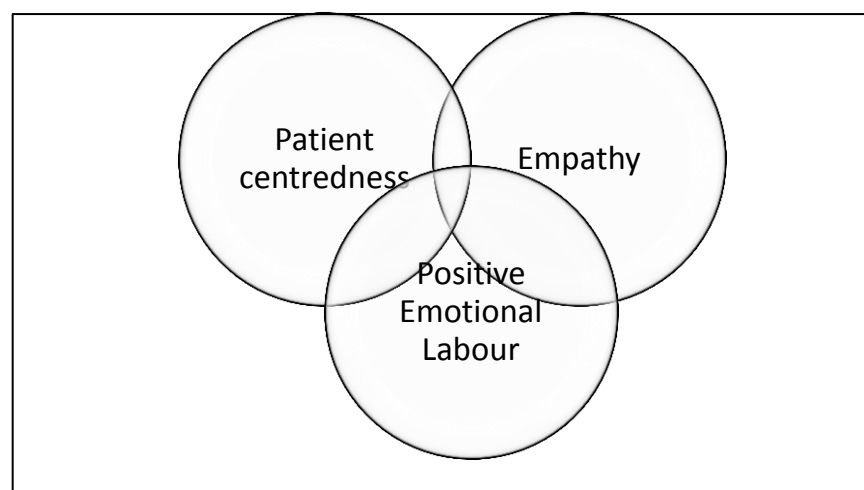
This more dynamic addition to Hochschild's theoretical understanding will be incorporated into the analytic process in order to understand how this understanding applies to other professional groups (GPs and pharmacists) within a different health care context (primary care).

Some authors have highlighted the positive aspects of emotional labour by viewing compassion and empathy as examples of emotional labour employed in 'caring work' (Smith, 2012). Smith (2012) also framed positive emotional labour within the framework of patient centred care



since they are inextricably linked to each other (see figure 3). Within a healthcare context, positive emotional labour could include the act or skill involved in recognising the emotions of others (for example, empathy). It is these aspects of emotional labour which will be the principle focal point of analytic enquiry for this research. Using emotional labour theory to examine professionals' responses to patients' emotional worlds and their feelings is useful since it endeavours to make explicit the acts and devices which professionals employ in emotional labour. Making emotional labour explicit and identifying the ways in which professionals respond to patients' feelings/emotions in the healthcare encounter may have implications for identifying future training and support needs of professionals working in primary care.

Figure 3: Inter-Related Model of Positive Emotional Labour



The next section reports the results of a systematic literature review identifying emotional labour employed by healthcare professionals in a healthcare setting. This section will employ the term emotional labour since it recognises that emotion work is employed within a work place context.

## **2.8 A Thematic Review: Emotional Labour in Healthcare Settings and Encounters**

The aim of the review was to identify emotional labour employed by healthcare professionals in a healthcare setting which includes the intrapersonal and interpersonal aspects of emotional labour employed when working within a healthcare setting. A healthcare setting refers to both primary and secondary healthcare settings, including hospitals and care homes. The review identifies what research has been undertaken in this area, the methods used to capture and examine emotional labour in various contexts or settings, to identify what has been found and potential gaps in research undertaken, to date. The methodology for undertaking the review was informed by guidance for thematic reviews as detailed by Cronin et al. (2008).

### **2.8.1 Search Strategy and Results**

The following five databases were systematically searched employing the key search terms indicated below: PubMed, International Bibliography of the Social Sciences (IBSS), PsychInfo, Embase, CINAHL and Web of Science. The search did not impose any limits by date. The search also undertook a cited author search using Web of Knowledge using key papers by Arlie Hochschild, (1979, 1983) who conceptualised the theory of emotional labour.

The inclusion criteria for the search were restricted to the following: papers in English, original research (not discussion/conference papers or secondary analysis); qualitative research employing qualitative analysis; use of emotional labour as a stated theoretical perspective.

The following search terms were employed in combined searches: emotion work/emotional labour/emotion management AND health care or health OR health professionals/healthcare professionals OR doctors/nurses/midwives/pharmacists/patients.

A flow diagram detailing the results from the systematic search is presented in Appendix A while a similar flow diagram for the cited author search using Web of Knowledge is given in Appendix B. The combined searches and assessment of papers in terms of whether or not they met

the inclusion criteria identified 12 relevant articles, which are presented in Table 1. The table provides information relating to the setting for the research, methods, method of analysis and key findings. The findings are discussed in depth in the following section.

Table 1: A summary of papers identified for the thematic view of emotional labour in a healthcare setting

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
Williams, A.	2013	UK	8 second-year undergraduate paramedic students (6 male; 2 female)	A qualitative, exploratory design using semi-structured interviews  Thematic content analysis	To explore and examine paramedic students' perceptions and experiences of emotion work and the strategies used to deal with it.  2 principal strategies were identified:	Williams, A. (2013). The strategies used to deal with emotion work in student paramedic practice. <i>Nurse Education in Practice</i> , 13; 207-212

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
					<ul style="list-style-type: none"> <li>• Talking it through and offloading to friends and colleagues, family and mentors.</li> <li>• Use of humour to 'off-load' and lighten difficult feelings.</li> </ul> <p>Authors argue that effective support and supervision needs to be in place to help manage students' feelings and thus indirectly benefiting patients.</p>	

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
Williams, A.	2013	UK	8 second-year undergraduate paramedic students (6 male; 2 female)  Paramedic service	A qualitative, exploratory design using semi-structured interviews  Thematic content analysis	Emotion work involved control and suppression of emotion, 'got to deal with it' and 'don't see them as a person'. Students struggled to deal with patients' and relatives' emotions and their own in some situations and subthemes included 'not sure of what to say', 'stop myself crying', and 'personal links'. The findings make visible the emotional demands of student paramedic practice and their	Williams, A. (2013). A study of emotion work in student paramedic practice. <i>Nurse Education Today</i> , 33(4); 368-72

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
					implications for training. The authors argue that recommend that training modules must prepare and support students to perform emotional labour effectively.	
<b>Rodriquez, J.</b>	2011	US	Nursing care workers  One private nursing home	Participant observation and 65 interviews with staff.	No stated objective  Having dignity at work was dependent upon establishing emotional	Rodriquez, J. (2011). "It's a Dignity Thing": Nursing Home Care Workers' Use of Emotions. <i>Sociol Forum</i> (Randolph, N. J), 26(2); 265-286.

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
				Grounded Theory	<p>attachments. When care workers were able to form emotional attachments with residents, they felt greater dignity at work. This was challenging given the economic drivers of care homes which reduced opportunities for workers to engage with residents due to time constraints.</p>	
<b>Gray, B. and</b>	2009	UK	Qualified, practicing nurses	16 in-depth	To identify the	Gray, B. and Smith, P. (2009). Emotional labour



Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
Smith, P.			within primary care, mental health and children's oncology	and semi-structured interviews.  Thematic analysis	experiences of nurses in relation to their feelings and emotional labour and to ask them to reflect upon their practices and emotions in different clinical settings.  Emotional labour was used to support relationships with patients, relatives and colleagues.	and the clinical settings of nursing care: The perspectives of nurses in East London. Nurse Education in Practice, 9; 253-261.

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
					<p>Reflection and supervision of emotions were important methods of preventing burnout and emotional stresses.</p> <p>Gender stereotypes often meant that female nurses were 'invisible carers' (taken for granted with emotions represented as a 'natural' activity) while male nurses were</p>	

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
					'forgotten carers'	
<b>Miller, K.L., Reeves, S., Zwarenstein, M., Beales, J D., Kenaszchuk, C. and Conn, L.G.</b>	2008	Canada	Nursing, medical and allied professionals in the general internal medicine wards of three hospitals in urban Canada.	Qualitative data using non-participant observation, shadowing and semi-structured Interviews with staff.  Content analysis.	To examine nursing emotional labour and inter-professional collaboration in order to understand and improve collaborative nursing practice.  Nurses' collaborations with other professionals are influenced by emotional labour	Miller, K.L., Reeves, S., Zwarenstein, M., Beales, J D., Kenaszchuk, C. and Conn, L.G. (2008). Nursing emotional labour and inter-professional collaboration in general internal medicine wards: A qualitative study. <i>Journal of Advanced Nursing</i> , 64(4); 332-343.

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
					<p>considerations. The establishment and maintenance of a nursing 'esprit de corps', corridor conflicts with physicians, and the failure of the interdisciplinary team to acknowledge the importance of nursing's core caring values are important factors underpinning nurses' inter-professional disengagement</p>	

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
<b>Weir, H. and Waddington, K.</b>	2008	UK	Call handlers, healthcare staff and assistants working in NHS direct  National Health Service Direct (NHS Direct)	Single site case study, employing a qualitative ethnographic approach. Data collection methods included non-participant naturalistic observation and in depth interviews with a range of staff.  Thematic	Focus on emotional labour in NHS Direct staff exploring the experience and emotional labour of nurses working in a call centre  Issues in caring without the face-to-face contact using communication technology were crucial to the way nurses perceived their work. These factors contributed to nurses' orientation to work and	Weir, H. and Waddington, K. (2008). Continuities in caring? Emotional labour in a NHS direct call centre. <i>Nursing Inquiry</i> , 15(1); 67-77.

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
				analysis.	to the way that conflict and dissonance with expectations of callers and managers impacted on nurses' emotional labour.	
<b>Theodosius, C.</b>	2006	UK	Staff nurses. NHS hospital	<p>14 months of participant observation, audio diaries and semi-structured interviews</p> <p>Narrative analysis and analysis using</p>	<p>To identify hidden and visible emotion processes in order to understand how they impact on emotional labour.</p> <p>The research methods (e.g. use of diaries) identified ways in which</p>	Theodosius, C. (2006). Recovering Emotion from Emotion Management. <i>Sociology</i> , 40(5);893-910.

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
				psychoanalytic tools of transference and counter-transference.	nurses employed hidden unconscious emotion processes to manage emotions	
Hunter, B.	2005	UK	27 student midwives and 10 hospital-based midwives National Health Service Trust	An ethnographic approach using focus groups, observations and interviews.  Theoretical framework of 'boundary maintenance' was used to	To identify and explore the emotional labour of hospital-based midwives.  For students, negotiating relationships with practicing midwives was a major source of emotional labour.	Hunter, B. (2005). Emotional labour and boundary maintenance in hospital-based midwifery. <i>Midwifery</i> , 21(3);253-66.

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
				undertake analysis	Although collegial relationships could provide support and affirmation, they were also a frequent source of conflict, particularly between junior and senior midwives	
Hunter, B.	2004	UK	27 student midwives, 11 qualified midwives, 29 midwives working within one NHS Trust	A qualitative study using an ethnographic approach. Data were collected in three phases using focus groups,	To explore how a range of midwives experienced and managed emotion in their work.  The key source of	Hunter, B. (2004). Conflicting ideologies as a source of emotional labour in midwifery. <i>Midwifery</i> , 20 (3); 261-72.



Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
				observations and interviews	emotional labour for participants was conflicting ideologies of midwifery practice: a medicalised model versus 'with woman approach' (person centred). Midwives who practised within hospitals experienced more inner conflict when working with a medicalised model which was more incongruent to their preferred ways of working. The emotional and ideological	

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
					dissonance which led to anger, frustration and anxiety requiring emotional labour.	
<b>Bolton, S.C.</b>	2000	UK	Gynaecology nurses, NHS Trust	<p>A qualitative study.</p> <p>Semi-structured interviews and observation in the gynaecology wards and in the outpatient clinics.</p> <p>Thematic</p>	<p>To learn how nurses feel the introduction of 'new' management has affected their work, especially the way in which they present themselves to patients.</p> <p>Nursing work is emotionally complex and may be better understood by utilizing</p>	<p>Bolton, S.C. (2000). Who cares? Offering emotional labour as a 'gift' in the nursing labour process. <i>J Adv Nurs</i>, 32(3);580-6.</p>

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
				analysis.	a combination of Hochschild's concepts: emotional labour as a 'gift' in addition to 'emotional labour'.	
<b>Gattuso, S. and Bevan, C.</b>	2000	Australia	Various qualified nurses practicing in aged-care nursing, care home and community/district nursing roles	Focus groups.  Method of analysis – not stated	To examine emotional labour within the predominantly female environment of aged-care nursing.  The nurses' narratives reflect the intersection of private and public caring in nurses' lives and the implications of	Gattuso, S. and Bevan, C. (2000). Mother, daughter, patient, nurse, women's emotional labour in aged care. <i>Journal of Advanced Nursing</i> , 31(4); 892-9.

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
					this for emotional labour. Phenomena such as dual caring, conflicts in insider-outsider roles, and transference were revealed in their narratives.	
<b>Staden, H.</b>	1998	UK	Three experienced enrolled nurses (level 2) who were on a course to convert their nursing qualification to registered nurse	Case studies using semi-structured interviews of three nurses.  Phenomenological	To recognise and value emotional labour and the skills involved and embodied within it.  All three women recognize emotional	Staden, H. (1998). Alertness to the needs of others: a study of the emotional labour of caring. <i>J Adv Nurs</i> , 27(1):147-56.

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
			(level 1).  NHS setting in a hospice, mental health ward, and haematology ward	analysis.	labour as work but also that this type of work is not recognised or valued by society. They were not able to name skills used for such work and generally believe that it is through life experience that they have learnt emotion management.	
<b>Smith, A. C. and Kleinman, S.</b>	1989	US	Medical students. Hospitals	Participant observation and semi-structured interviews.	To examine how students learn to handle unsettling reactions to patients and procedures in a context in which faculty members expect	Smith, A.C, & Kleinman, S (1989). " Managing Emotions in Medical School: Students' Contacts with the Living and the Dead." Social Psychology

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
				Thematic analysis	<p>students to socialise themselves.</p> <p>Students use a range of emotionally distancing strategies to cope with unsettling situations which include de-sensitisation strategies which exclude psychosocial aspects of the patient's world (feelings, values, and social context); distancing relying on the objectivity of western medicine to</p>	Quarterly, 52 (1); 56-69.

Author(s)	Year	Country	Sample, setting	Design and Analysis	Aim/Objective and Main Finding	Reference
					distance themselves; and derogatory humour.	

## **2.9 Review Findings**

For those 13 studies meeting the search criteria, the findings and discussion sections of the papers were reviewed using the following strategies, which have been previously outlined by other authors (Cronin et al., 2008). The findings and discussion points presented in the papers were identified and annotated in the margins of the paper. Main themes and second order constructs provided in the discussion section were noted, while the following contextual information on author, date, country and information describing the study design, method of analysis, aim/objectives of the study and key findings were recorded and entered into a table. This process was repeated for each of the papers. The themes and interpretations were then sorted and arranged into broader re-occurring themes undertaken as an inductive process. Descriptive accounts of these broader themes were written and employed when reviewing the themes below.

The reviewed studies (N=13) employed a range of qualitative methods to explore emotional labour in healthcare professionals. The approaches predominantly employed ethnographic methods, such as participant observational methods in combination with interviews or diary methods, to explore aspects of emotional labour such as the lived experience of emotional labour and strategies for professionals' emotion management. The focus of these studies was centred on the more intrapersonal aspects of emotional labour theory, which observe or invite professionals to reflect on the meanings, challenges and positive aspects of emotional labour and emotion self-management in their professional lives.

The focus of emotional labour research varied across the studies but a thematic review employing the review process previously discussed, identified the following five aspects of emotional labour/emotional labour within the included studies:



1. Gendered aspects of emotional labour– a critique of emotion as ‘women’s work’
2. Intrapersonal aspects of emotional labour – how healthcare workers manage their own emotions in the workplace
3. Inter-Professional aspects of emotional labour – how emotions are managed between professional groups
4. Support and training needs of professionals –identifying the importance of support and training in enabling professionals to manage their emotions and those of others (patients and colleagues)

These themes are discussed in more detail below.

### **2.9.1 Gendered Aspects of Emotional Labour**

One of the key observations gained from reviewing the 13 papers is that a considerable proportion of the research on emotional labour/emotional labour in a health care context is focused on the nursing professions. Of the 13 papers reviewed, 6 studies focused on the nursing professions (Miller at al., 2008; Gray and Smith, 2006; Theodosius, 2006; Bolton, 2000; Gattuso and Bevan, 2000); 2 papers focused on midwifery (Hunter, 2005; Hunter, 2004); 2 papers focused on paramedic students (Williams, 2012); 1 study on medical students (Smith and Kleinman, 1989); 1 study on NHS Direct staff who included nurses (Weir and Waddington, 2008) and 1 paper on emotional labour in healthcare assistants (Rodriquez, 2011). The predominance of research focused on nurses is useful to reflect on, perhaps as Bolton suggests, because nurses are perceived as being a caring profession whose work involves a significant amount of emotional labour (Bolton, 2001).

While the studies identify a range of emotional labour employed by nurses, such as strategies to present a ‘professional face’, the authors also reflect that a considerable amount of emotional labour is driven by patient and societal expectations of nurses’ ability to care. In addition, some authors commented on the gendered nature of emotional labour carried out by nurses, and the taken-

for-granted assumptions of women as 'natural carers' (Gray and Smith, 2009; Gattuso and Bevan, 2000). Gray and Smith (2009) observed that gender stereotypes often meant that female nurses were perceived as 'invisible carers' whose caring ability was seen as natural because they were women. Male nurses, on the other hand, were often perceived as 'forgotten carers' who were constrained by societal rules and expectations relating to intimacy and distance. This included assumptions about whether it would be more acceptable for a female nurse to touch a patient than it might be for a male nurse.

### **2.9.2 Intrapersonal Emotional Labour**

The second re-occurring theme identified in the review was the intrapersonal aspects of emotional labour – this theme relates to some of the challenges of emotional labour in managing one's own emotions and also those of others. Some authors identified examples of emotional labour or emotion management seen as unhelpful and potentially stressful for professionals. Some authors identified ways in which different healthcare professionals managed difficult feelings, and highlighted the importance of support and supervision in the management of emotions, and crucially in the prevention of stress and burnout (Williams, 2012; Gray and Smith, 2009). For example, Williams (2012) observed that paramedic students suppressed emotions and struggled to manage their emotions and those of their patients and carers. As a result, the authors recommended that support and supervision be put in place to empower and equip professionals to manage difficult emotions. The authors argue that ultimately, this would benefit patients while preventing potential stress and the possibility of burnout in professionals. This is discussed in more depth under the theme of 'support and training needs'.

From their observations of and interviews with medical students, Smith and Kleinman (1989) also identified the ways in which students employed a range of emotionally distancing strategies to cope with unsettling situations which included the employment of de-sensitisation strategies such as excluding psychosocial aspects of patients' worlds (feelings, values, and social context); and using the cloak of biomedicine as a distancing strategy which involved an

(over) reliance on the rationality and objectivity of western medicine to distance themselves from difficult feelings. The authors also observed that students used derogatory humour to de-humanise their patients as a strategy to avoid difficult feelings which also relied on strategies to distance themselves from their patients. The authors concluded that there was a lack of training to assist doctors in emotion management to enable them to respond more empathically with their patients (Smith and Kleinman, 1989). With the exception of this study by Smith and Kleinman (1989), there was a noticeable gap in the literature of emotional labour used in studies to understand the ways in which professionals, particularly doctors, managed their emotions and how this impacted on the approaches to managing the emotions of their patients.

Intrapersonal aspects of emotional labour also relate to ways in which professionals needed to manage inner conflict within the workplace. For example Weir and Waddington (2008) observed that professionals, mainly nurses, working for NHS Direct were faced with the difficulty of managing the emotions of callers when they did not have face-to-face contact with them. Other conflicts emerged from ideological conflicts and stress arising from emotional dissonance in midwives who had difficulty working to a biomedical model of midwifery when they were ideologically committed to a community model. The latter model focused more on the psychosocial needs and wellbeing of women and their families and was therefore at odds with the rationalist underpinning and disembodied approach of the biomedical model (Hunter, 2005).

Other aspects of intrapersonal emotional labour to be considered relate to those aspects which are viewed as 'positive' and those that are hidden or those that may be overlooked. The identification of these aspects of emotional labour has brought the concept of emotional labour within a healthcare context under scrutiny by some authors (Theodosius, 2006; Bolton, 2000) who argue that the term underestimates and oversimplifies the motivations and altruistic nature of healthcare professionals' work. It is argued that nursing as a profession is often associated with the satisfaction derived from engaging in emotional labour.

Theodosius (2006) and Bolton (2000) of these studies contest the extent to which workers' feelings are commodified within a healthcare setting and suggest

that some emotional labour can, to some extent, be free from organisational demands. It is argued that health professionals such as nurses have the opportunity to present their 'authentic selves' in 'unmanaged spaces' in places deemed free from management control (Bolton, 2000). For example, some aspects of emotional labour have been conceptualised as more of a 'gift offering' in a similar way to Hochschild's notion of 'gift exchanges' in individuals' private spheres. This includes nurses who appear to go beyond the call of duty to provide care and compassion to patients who are in distress, such as when managing women who are grieving for the loss of their babies through late miscarriages or late terminations (Bolton, 2000).

Similarly, the finding is echoed in care home workers who indicated that they derived more satisfaction when they had the opportunity to develop more intimate relationships with care home residents but that this was often constrained by the economic drivers of care homes. Additionally, Theodosius argues that there are considerable unconscious processes taking place in the way nurses manage their emotions which are often hidden from the emotional labour lens (Theodosius, 2006).

The concept of emotional labour may also overlook positive aspects of emotional labour/work in the workplace. One such example, observed by Bolton (2000), is the way nurses employ humour as a way of managing emotions on a gynaecology ward. Humour enabled nurses to manage their emotions within an environment that could be charged with a range of complex and challenging emotions such as grief, frustration or anger (Bolton, 2000).

### **2.9.3 Inter-Professional Emotional Labour**

The third theme relates to the inter-professional aspects of emotional labour which refers to the way emotional labour is employed to support relationships with colleagues. Miller et al. (2009) identified that nurses' emotional labour in this area was often taken-for-granted, which frequently led to disengagement and inter-professional conflict. Hunter (2005), on the other hand, observed inter-professional conflict between junior and senior midwives. However, it can be noted that this and other studies do not always attend to the dynamic

aspects of emotional labour and how individuals actively co-construct and manage others and their own emotions within this dynamic relationship.

#### **2.9.4 Support and Training Needs**

The fourth and final theme identified in the review is the identification of support and training needs by the study authors based on the research findings. In terms of future work in the area of emotional labour and healthcare, some authors call for emotional labour to be made more explicit in terms of identifying the range of emotional labour that is carried out and ways in which emotion management, for instance, is helpful and unhelpful to both patients and professionals. In this way, emotional labour can be made explicit rather than taken as an assumed aspect of a professional's role for which training and support are often overlooked (Williams, 2012; Gray and Smith, 2009). Despite calls to value emotional labour and deconstruct taken-for-granted knowledge around women as natural carers, nurses in Staden's (1998) study contradict this viewpoint since they perceived emotional labour as a life skill, acquired through life experience. Perhaps those views support assumptions around emotional labour as a 'natural' skill which is consequently more likely to be overlooked and undervalued, particularly in the nursing professions.

To summarise, the focus of emotional labour in the nursing professions may perhaps reflect assumptions and expectations around the role or capability of nurses to undertake or engage in emotional labour. It is argued that the focus on nursing and lack of focus on doctors (or other healthcare professionals) may reflect socio-cultural heuristics influencing who can/should provide emotional labour (Larson and Yao, 2005). Greenberg et al. (1999), for instance, reported that doctors attach little importance to empathy and that other factors such as workload and insufficient training in the area of emotion management may influence the ways in which doctors engage with their patients on an emotional level. Another study by Smith and Gray (2000) reported that doctors frequently perceived emotional labour within the remit of nurses' work while nurses perceived that doctors often left them to 'pick up the emotional pieces' (Smith and Gray, 2000: 49). With the extension of prescribing, nurses and pharmacists assume roles and responsibilities which were previously the domain of doctors.

With these changing roles, it would be useful to understand if the emotional labour traditionally assumed by or expected of female nurses continues to persist. Little is known about the emotional labour of pharmacists within any healthcare context and therefore this study may offer a contribution to an under researched area in relation to pharmacists.

In the 'caring' professions such as nursing, emotional labour has been defined as the way in which the worker or professional may be expected, from an organisational, personal/professional or societal standpoint, to manage emotional performances which can require considerable effort and engagement with their patients (Smith, 2012). While this is not contested by authors across the studies, some authors have questioned the application of aspects of Hochschild's thesis to the healthcare setting and in doing so draw attention to the more complex and dynamic aspects of emotional labour: that satisfaction can be gained by offering emotional labour and that additional satisfaction is derived from the ways in which it is appreciated by patients. However, counter arguments highlight that when emotional labour occurs within any organisational setting, such as a hospital, the worker can never truly be free from organisational demands placed on their emotional selves (Brook, 2009).

With the exception of Theodosius (2006), the emotional labour lens employed across these studies tended to focus on the emotional labour of the professional, often in isolation to the patient. This is reflected in the methods employed across the studies, for example, in observational methods or in the employment of interviews with professionals in which patients' or carers' views/perspectives are omitted from the research. This focus of previous research tends to overlook the more dynamic nature of emotion work without explicit recognition of emotion communication as a relational and collaborative encounter with patients. The focus of this PhD in the qualitative analysis will make reference to the more dynamic relational processes involved in the management of patients' emotionality.

With exceptions (e.g. Theodosius, 2006; Bolton, 2000) the literature included within this review does not critically engage with the Hochschild's original theory. In particular, the literature does not consistently challenge the relevance of Hochschild's underpinning social theory (feminism and Marxism) as

applied to different healthcare contexts. Additionally, the ontological underpinnings of social constructionism, which provide a lens to deconstruct the influence of socio-cultural 'feeling rules' in the employment of emotional labour, have also been neglected in some studies.

These debates and contestations about the applicability of emotional labour within a healthcare context have raised important points which will be considered when conducting the analysis and interpreting the findings from this study. Furthermore, this study will critically engage with Hochschild's theory and test its applicability to general practice, in particular, by using its feminist and Marxist underpinnings to understand their relevance and ways in which socially constructed heuristics may be operating in the consultation and institutional setting.

### **2.9.5 Conclusion**

Using the theory of emotional labour, it is possible to de-construct and critically analyse the ways in which emotions are communicated and managed in the healthcare encounter. The analysis for this research will attend to ways in which patients' feelings are managed in the healthcare encounter, being attentive to feeling rules and the ways in which patients and professionals may co-construct the communication of feelings and how both actors may collude in the way feelings are expressed and/or managed within the healthcare encounter, will be important to identify. The analysis will also be interested in the ways GPs, nurses and pharmacists employ emotional labour in consultations with patients. The analysis will question the extent to which their communication and management of feelings may be influenced by feeling rules or other influencing factors. One indication may be found in the scripts/narrative or discourse employed by professionals and in the extent to which professionals engage with patients' emotionality.

The analysis, and its attention on the emotional labour employed by patients and professionals to communicate and manage emotional cues and concerns within the encounter, will contribute to our understanding of emotional labour

employed by GPs, nurse and pharmacists within the setting of general practice. In revealing and making explicit the type of emotional labour undertaken by professionals across these groups, it will enable the communication skills involved in carrying out emotional labour to be recognised and valued. Furthermore, in making emotional labour explicit, it is hoped that potential training and support needs will be identified to enable professionals to respond and manage emotionality in the healthcare encounter more effectively. This is valuable given the increasing levels of stress and burnout experienced by doctors in primary care and its detrimental impact on patient care such as reduced capacity for empathy (Bruce et al., 2005; Arnetz, 2001).

Additionally, by drawing on the feminist traditions of emotional labour, it will be useful in highlighting gendered aspects of emotional labour employed by GPs, nurses and pharmacists in this study. Moreover, the Marxist underpinnings of Hochschild's commodification thesis may shed light on the extent to which workers' feelings may be influenced by the demands of the institutional setting. To what extent are GPs, nurse and pharmacist prescribers' feelings free of or owned or influenced by the demands of primary care? Being critically aware of these macro level socio-cultural influences on the employment of emotional labour, the application and applicability of Hochschild's original theory can be tested in the setting of general practice. Additionally, the value of drawing on social theory comes from its potential to offer explanations for phenomena and provide a more sophisticated understanding of the barriers and facilitators to positive emotional labour. Some of the literature employing a more quantitative approach (e.g. Levinson et al., 2000) lacks any social theoretical underpinning or substantive ways of accounting for patients' cues and concerns or professionals' responses to them. These studies offer a descriptive account of the study phenomena but not an explanatory or interpretative one.

This chapter has revealed the complexity of this topic. The consultation process and what patients and professionals think, feel and act occur within a dynamic encounter which is complex and potentially influenced by a myriad of micro and macro-level factors. The literature highlights the clinical and therapeutic value of patient centred approaches; namely, valuing the patient as a person, recognising and understanding patients' wider health and illness experience, listening, empathising, and involving the patient in the communication process



including decision making about treatment. This chapter has highlighted some of the key barriers and facilitators of adopting this approach, including consultation skills and sociocultural feeling rules that influence the ways in which patients and professionals manage their emotionality. This chapter explored the range of methods which have been employed to study this topic and has highlighted their strengths and weaknesses. A critique of the literature and methods when designing the methodology for this study has been undertaken, which also incorporated social theory to provide an additional lens through which this study phenomena can be explored and understood.

The next chapter will present the study methodology – a mixed methods approach to understanding and exploring the ways in which GPs, nurse and pharmacist prescribers respond to and manage patients' cues and concerns in healthcare encounters.

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# Chapter 3: Methodology – a Mixed Methods Approach

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### **3.0 Overview of Chapter**

The initial section of this methodology chapter begins with an explanation of the context in which this research took place which includes information about the design and impetus for this work. The following section discusses the rationale for choosing a mixed method approach including the key methodological, epistemological and theoretical reasons for doing so. The subsequent section describes the process of obtaining ethical approval while the next section describes the sites used for this study and approach for recruiting participants (professionals and patients).

The next section describes the first phase of the research which includes an in-depth discussion about my involvement in the development of the coding framework for this phase and responsibility for undertaking the analysis. This is followed by a description of the process of preparing the data and approach to the analysis while the subsequent section discusses credibility and validity issues related to the coding process and inter-coder reliability.

The second part of this chapter focuses on the second phase, the qualitative analysis of a sub-sample of consultations from phase one.

### **3.1 Context of Research**

I was employed as a Research Officer on a Leverhulme funded study between July 2009 and May 2012 at the University of Bath. The Leverhulme funded study was conceived and designed by the principal investigator (MW), and set out to compare the consultation styles of three prescribing groups working in primary care: GPs, nurse and pharmacist prescribers. The research focus on consultation styles centred on the opening of the consultation, the process of decision making around treatments and empathic communication in the consultation. The interest in these three groups stemmed from the new roles and responsibilities afforded to nurses and pharmacists who have legally been able to work as independent prescribers due to the extension of prescribing in 2004. Due to the extension of prescribing, the Leverhulme funded study aimed to consolidate the literature on aspects of communication and consultation styles focusing on nurses and pharmacists with GPs as a comparison group.

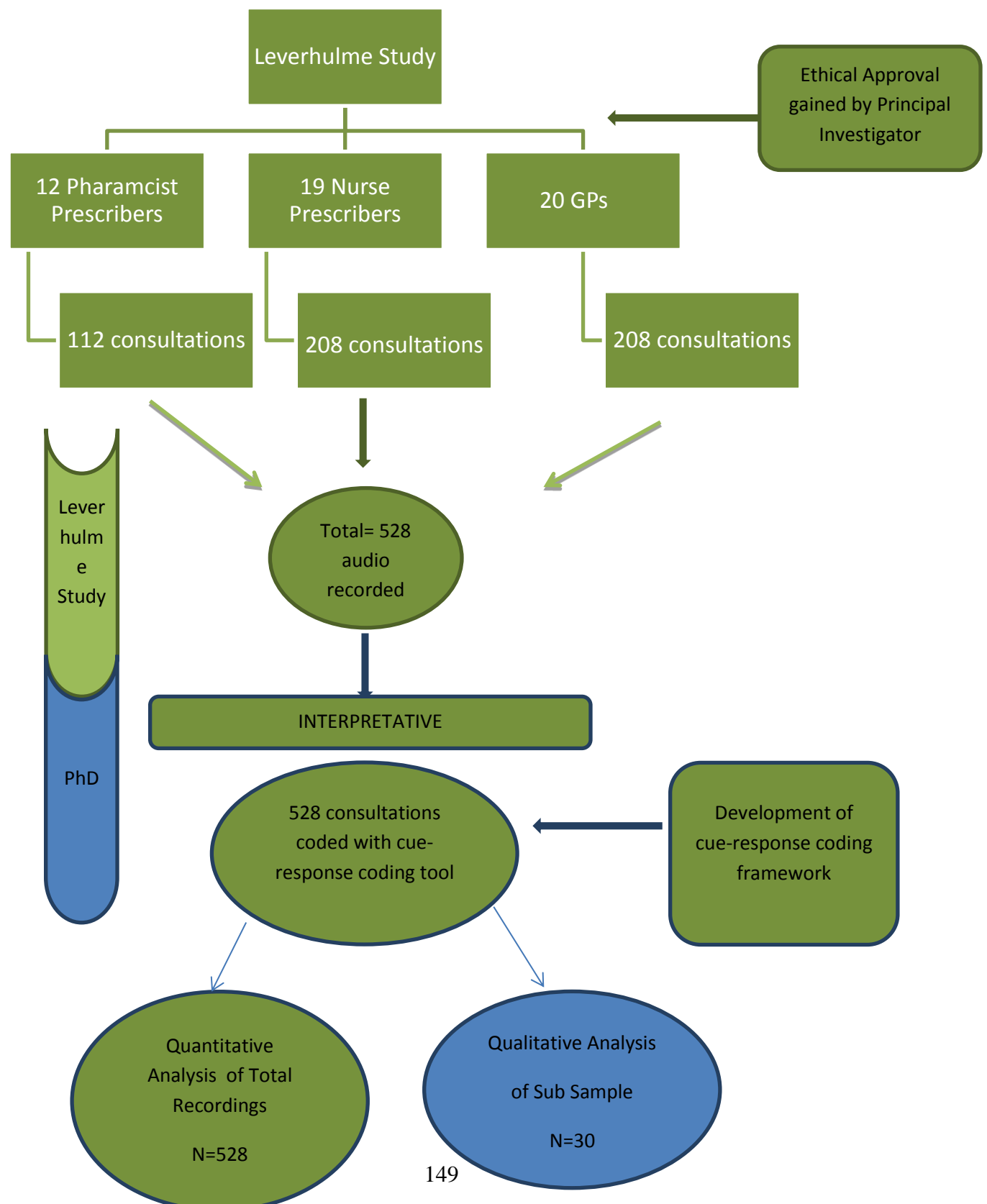
As a starting point from which to examine empathic communication in consultations, MW identified a paper by Levinson et al (2000) which reported the findings of a study comparing doctors' responses to patients' emotional clues. This paper served as the foundation for the coding framework developed for the first phase of this research. The second phase was conceived and developed whilst undertaking the first phase of the study. While coding the data in phase one, it became apparent that the coding framework which focused on the cue-response sequence alone was insufficient to understand the process of emotional labour within context. Consequently, the qualitative phase was developed to address this limitation.

Due to my research interests in more holistic healthcare incorporating a more narrative and patient centred approach, I registered to do a PhD in January 2010 with the aim of utilising the data (the audio recorded consultations) collected during the course of the Leverhulme study. In conjunction with colleagues, I was responsible for steering the intellectual development of the coding tool/coding framework and piloting of the coding process between the second researcher assigned to the project (JP) and myself. The process of developing the tool involved considerable intellectual investment, and in addition, I was responsible for designing the second phase of the study which has been

incorporated into my research to provide an in-depth approach to understanding the communication and management of emotions/feelings during healthcare encounters. The first phase enabled more general comparisons to be made across the professional groups in terms of their responses to patients' emotional cues and concerns by analysing the data quantitatively. The second phase was employed for the purposes of method and theory triangulation in order to strengthen the findings of the research. Whilst coding the data for phase one, it highlighted some of the methodological weaknesses of employing a coding framework to understand how professionals manage patients' concerns. These are discussed later on in this chapter.

The flow diagram in Figure 4 provides an overview of the data collection, coding and analytic stages of the mixed method approach. I have distinguished which phases of my Research are associated with the Leverhulme study and the additional data analysis undertaken as part of my PhD research.

Figure 4: Flow Diagram Depicting the Data Collection and Data Analysis in the Mixed Method Phase in the Study



### **3.2 Introduction to Mixed Method Approach**

Creswell and Plano Clark (2007) state that mixed methods research, as a method, 'focuses on collecting, analysing, and mixing both quantitative and qualitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches, in combination, provides a better understanding of research problems than either approach alone.' (Creswell & Plano Clark, 2007: 5). In the context of this study, mixed method refers to the mixed approach to data analysis and use of theory using the same audio recorded data. In this respect, phase one employed a quantitative approach to analysing the coded data whereas phase two undertook qualitative analysis to explore the management of emotionality and exploration of facilitators and barriers to doing so, taking account of the consultation process and wider context of the setting.

Additionally, mixed method also refers to the mixing or addition of theoretical perspectives with which to view the study phenomena. Phase one and two both drew upon the theoretical basis of patient centred medicine and paradigm shift associated with it. Both phases have built upon the theoretical and empirical evidence relating to the literature on healthcare professionals' responses to patients' cues and concerns. With respect to phase two, the addition of emotion work theory, its underpinning social theory (Marxism, feminism), was viewed as a useful addition to enrich the analytic process, particularly given the dearth of theoretical traditions underpinning previous coding systems. The addition of this phase was included to enhance understanding about how patients' emotionality (their cues and concerns) are managed in the consultation process by different professionals within the workplace. As previously mentioned, this phase was developed iteratively, in response to emergent weaknesses or challenges of employing a cue-response coding framework which are discussed below.

The employment of a mixed method approach was considered beneficial in the following ways. Phase one employed a coding framework to code the nature of patients' cues and prescribers' responses to them. This coding framework provided a useful method for coding a large data set and to enable more generalisable comparisons to be made between the professional groups.

However, it was felt that this method alone would not enable me to examine the nuances and complexities of the way in which emotions are communicated and managed in healthcare encounters in more depth (Fineman, 2005; Baker et al., 1996). Therefore, the rationale for adopting a mixed method approach to this research was a pragmatic decision – different methods needed to be employed in order to answer different research questions about the study phenomena. It was felt that the complexity of the research topic – comparing, identifying and understanding the ways in which different prescribers manage patients’ cues and concerns in healthcare encounters– could not be answered by one method alone. The value of a mixed method approach is echoed by Patton who called for a ‘paradigm of choices’ as ‘different methods are appropriate for different situations and questions’ (Patton, 1988:119).

### **3.2.1 Theory**

This research has drawn upon the following paradigmatic or theoretical developments in the field of health and illness and sociology of emotions:

1) The biopsychosocial model of health and illness provides a framework for understanding health and illness and dimensions of health and healthcare which are communicated in patients’ emotional cues and concerns. The bio *and* psychosocial model of health represents a paradigm shift away from the biomedical model of health and illness since the latter model was viewed as a dualistic, disembodied approach to understanding health and illness, according to critics (Engel, 1977). This dynamic model or approach to understanding health and illness is underpinned by an interpretivist epistemology which acknowledges the multidimensional influences (i.e. socio-cultural) on people’s understanding and experiences of the world around them – this includes the way people experience the world with both body and mind; that social, emotional and physical factors influence people’s experience of health and illness (Engel, 1977; Kleinman, 1998). The biopsychosocial model was later operationalised as an approach and ethos in healthcare by patient centred care which considers patients’ wider needs and narratives within a more dynamic and more democratic consultation process (Epstein, 2005; Mead and Bower, 2000).



2) Hochschild's emotion work theory (1979, 1983) which was underpinned by a social constructionist ontology drew on Marxist and feminist traditions in order to deconstruct and question taken-for-granted knowledge around gendered aspects of emotion work and power of the institution in influencing or owning workers' feelings. While Hochschild's original theory has been developed and adapted for its application within a healthcare setting (Smith, 2012; Theodosius, 2008) its epistemological and ontological roots provide a useful framework for critically understanding the employment of emotional labour within the primary care setting and potential barriers to doing so.

### **3.2.2 Epistemological Underpinnings of the Mixed Method Approach**

Both approaches to coding the data were underpinned by an interpretivist epistemology since the process of listening to recorded consultations, identifying cue-response sequences and categorising and understanding them required the researcher to interpret the meaning of patient's cues and concerns and prescribers' responses. However, the two methods differ in their approach in terms of the way in which the data were coded and analysed. The first phase of the study lends itself to an approach to data analysis that enables the researcher to make more generalisable comparisons about professionals' responses across the three groups using a larger data set (N=525 consultations). This phase categorised patient's cues and concerns and the nature and type of prescriber response (categorised as missed or positive) using a pre-existing coding framework, albeit one that was developed iteratively for the purpose of this data set.

The second phase was focused on exploring the ways in which professionals employ emotional labour to manage patients' emotionality while gaining a more in-depth understanding of the types of barriers and facilitators to employing positive emotional labour during the consultation process. While phase one coded the cue-response sequence as one of two categories (positive or missed), the second phase was more interested in identifying emotional labour processes both in response to specific iterations expressed by the patient and emotional

labour employed throughout the consultation. The process analysis approach will enable the researcher to identify the barriers and facilitators which may be impacting on the employment of emotional labour in the consultation process.

The qualitative analysis also enables the researcher to explore the ways in which emotions are communicated and managed in human interaction within a health setting, in more detail. In particular, the qualitative phase enables greater attention on the more dynamic aspects of emotional labour while acknowledging how feeling rules may influence the employment of emotional labour within a particular organisational setting or within a specific professional group.

Analysing talk in interaction using transcripts captures the rich, in-depth and nuanced aspects of communication in the health care encounter (Seale & Silverman, 1997). This phase has drawn upon several research traditions within the field of medical sociology particularly consultations analysed from a more critical framework or analytic methods which have provided detailed contextual descriptions of the health care encounters. Such critical approaches include discourse analysis (such as Barry et al, 2001) or interactionist aspects of emotion communication and management in healthcare encounters which acknowledges that social interaction including what feelings we express and how it is managed are influenced by socio-cultural feeling rules (Goffman, 1959; Fineman, 2003).

An interpretative approach to both phases requires an acknowledgement of the subjective and interpretative nature of the coding process. Neither phase assumes the researcher takes an objective and value free stance, but rather the reverse is true, that the researcher makes explicit the 'value-laden nature of inquiry' in both phases (Denzin and Lincoln, 1998: 8).

Incorporating a mixed-method approach also adds to the rigour and credibility of the research process and findings (Johnstone, 2004) since comparisons can be made across professional groups using a quantitative approach to data analysis. Employing qualitative analysis enables the researcher to undertake a more detailed scrutiny of how emotions are managed within healthcare encounters throughout the consultation process – both phases can generate useful and pragmatic research findings to inform how these relate to both patients and professionals.

The research is also interested in comparing the mixed method approaches to understanding emotion management in a healthcare context. In particular, the study will critique the methodological strengths and weaknesses of both approaches in understanding the study phenomena. These debates will be addressed in the concluding Chapter 6.

### **3.2.3 An Epistemology of Emotion**

One of the key philosophical underpinnings of both phases of the research is the assumption that a researcher can gain knowledge about our social worlds, specifically our emotional worlds, through our emotional senses in addition to deriving knowledge through thinking. It assumes that our understanding of our emotional worlds is derived through feeling and thinking. This understanding concerning how we gain knowledge and how we come to know what we know can also be applied to the way in which researchers gain knowledge about their worlds. According to Hubbard (2001) emotionally sensed knowledge is utilised by researchers throughout the research process, for instance, in informing research questions, whilst collecting data, analysing data and in interpreting data and that 'emotions are the means by which we make sense of and relate to our physical, natural and social world' (Hubbard, 2001: 126). This approach encourages and permits the researcher to use their feelings about the data as data itself in order enable them to interpret the data and derive emotionally sensed knowledge (Longhurst et al., 2008; Hubbard, 2001). With this philosophical viewpoint in mind, I am mindful of having employed both emotional and cognitive senses throughout the research process and, in particular, during the analysis and interpretation of the data. The qualitative analysis perhaps relied more on knowledge derived through emotional senses as compared with relying on cognitive sensing whilst, for example, categorising responses and undertaking quantitative analysis in the first phase.

The qualitative analysis considers the context of the patients and professional interaction within the entirety of the consultation and is able to identify additional contextual information which may help or hinder the way emotions are communicated and managed. My interpretations are influenced by what is expressed and how it is expressed and how feelings are managed within this context. There is also greater scope for discussion regarding my interpretations and observations which may contribute to a more in-depth discussion about the phenomena of interest to this study - the communication and management of emotions in healthcare encounters. My 'feelings' about the data are documented in diary entries which accompany the qualitative findings in Chapter 5.

### **3. 3 Obtaining Ethics**

Ethical approval was obtained from the Wiltshire Research Ethics Committee (Appendix C) by the study's principal investigator (MW) and from thirty-five local Research and Development offices in Southern England, including Greater London. Research passports or letters of access were obtained by both researchers (RR & JP) from the 35 participating local research and development offices.

### **3.4 Study Sites and Participants**

The health professionals (GPs, nurse and pharmacist prescribers working in primary care) were recruited through a rolling recruitment via third party recruiters (such as non-medical prescribing leads) and the primary care research network (PCRN) who posted adverts and targeted specific research-active practices. A total of 179 practices were targeted in the south west region while 1600 practices were sent information about the study in Central and Greater London to target pharmacist prescribers only. The study recruited GPs, nurse and pharmacist prescribers, the latter two needed to have undertaken and completed their independent prescriber training and were required to be actively running consultations in primary care in which medicines were prescribed or being managed.

It should be noted that the PCRN network in Central and Greater London differs from other regions in that all practices are included in the primary research network of practices rather than the opt-in system of research active practices that exists in other regions such as the south-west of England. However, due to the low number of pharmacist prescribers actively working and writing prescriptions within a primary care setting, it was not known how many of those practices contacted in London had an independent pharmacist prescriber who was running consultations. Consequently, the uptake or expressions of interest in the study is not known as a proportion of the overall eligible practices and as a result the response rate cannot be calculated.

Both researchers (RR, JP) visited interested practices to explain the study and obtain consent from health professionals. Prospective participants were also given a professional information leaflet which provided information about the study and research governance information relating to confidentiality and data protection regarding the storing and access of the audio recorded consultations (Appendix D). Participants were informed that the general focus of the study was concerned with the consultation styles of different prescribing groups in consultations in which a decision or discussion about a medicine would take place.

Once professionals and practices opted into the study, they were asked to sign a consent form (Appendix E) whereupon the researchers would arrange a time to visit. The reception staff were requested to give patients a study information sheet (Appendix F) and asked if they would be happy to see a researcher who would explain the study in more detail. This provided patients with the opportunity to opt out without feeling obligated to see the researcher.

The researchers also requested reception staff to exclude patients who had a significant intellectual (severe learning difficulty) or cognitive impairment (e.g. being diagnosed with Alzheimer's or dementia) or patients who could not speak English fluently (i.e. did not need the assistance of an interpreter) and patients under 16 years of age were also excluded.

When patients had had sufficient opportunity to read the information sheet about the study, one of the researchers approached the patient in the waiting room, explained the purpose of the study and reaffirmed guarantees relating to the confidentiality and anonymity of the recorded consultation. Patients were then asked if they had further questions pertaining to the study and were then asked if they would be happy to take part. Once patients verbally agreed to take part, the researcher then obtained patients' written informed consent (Appendix G) in the waiting room prior to their consultation with their prescriber. Patients were subsequently given a unique patient identification number which they were requested to give to their prescriber when they walked into the consultation room.

Recruited health professionals were provided with an audio recorder in their consultation room and were asked to record consultations with patients who had agreed to take part using their unique number to identify each recorded consultation. Professionals were asked to record the entirety of their consultations, from the opening to the close of the consultation unless patients requested otherwise.

### **3.4.1 Purposive Sampling**

Given the interest of the original Leverhulme funded study in 'new' prescribers and their consultations, it was considered important to recruit pharmacist and nurse prescribers who had undertaken their training in a range of training providers to avoid any possibility that prescribers' consultation style could be attributed to any particular training provider. The sampling strategy also set out to recruit professionals from practices located in a mixture of locations which included urban, suburban, town and rural. The strategy also set out to recruit an equal number of male and female professionals per group and nurses and pharmacists with different specialisms or areas of competencies such as asthma, diabetes or blood pressure. Since GPs tended to be 'generalists' in terms of what they prescribed, this criteria was less relevant in the recruitment of GPs. Table 2 provides an overview of the sampling criteria employed in the recruitment of

study participants. The rationale for adopting a purposive sampling technique was not on the grounds of trying to ensure a representative sample as would be required within a positivistic framework but to ensure maximum variation within the sample to generate hypotheses about the types of consultations sampled. Providing information about this context and potential factors which may influence the findings ensures its transferability to other contexts by providing what Guba and Lincoln (1994) describe as 'thick description'.

Table 2: Purposive Sampling Framework

<b>PRESCRIBING GROUP</b>	<b>LOCATION  URBAN, SURBURBAN TOWN, SEMI- RURAL, RURAL</b>	<b>GENDER</b>	<b>SPECIALITY OF PRESCRIBER</b>	<b>PROVIDER OF INDEPENDENT PRESCRIBER TRAINING COURSE</b>
<b>GPs</b>	x	x	NA	-
<b>Nurses</b>	x	x	x	x
<b>Pharmacists</b>	x	x	x	x

Whilst recruiting pharmacists during the study, it quickly emerged that the overall population of pharmacist who were actively using their independent prescribing qualification in primary care were limited. The numbers of pharmacists who were managing patients' treatment in consultation, was relatively small. As a result pharmacists were recruited through a range of opportunistic and snowballing techniques which relied on information supplied about the existence of working pharmacists by previously recruited pharmacists. In addition, to facilitate further recruitment, the study sites were extended to inner and greater London where an additional four pharmacists were recruited.

In the next section, the guiding philosophy underpinning the quantitative phase will be described followed by the aims and objectives of this phase and a description of how the cue-response coding tool was developed. The following

sections describe the process of preparing the data for analysis in SPSS and assessing the normality of data to inform the choice of statistical test. This section will conclude with a discussion about issues related to the credibility of the data such as the validity of the coding tool and an assessment of inter-coder reliability.

### **3.5 Data Collection**

A non-participant observational method was employed in the data collection phase to this study which provided the researcher with the opportunity to capture interactional data in its natural setting (Silverman, 2001; Mays & Pope, 1995). This so-called naturalistic method of inquiry using audio recorded consultations was employed since it enabled the researcher to capture health care interactions between the patient and their respective health care professional comprising a GP, nurse or pharmacist prescriber without requiring the researcher to be present.

This particular method of data collection also enables the researcher to systematically collect and access rich interactive talk between patients and professionals. Audio recording the consultations also allows the consultations to be transcribed while repeated listening of the consultation is advantageous for the analytic process, for example, when listening to nuances in paralinguistic features of talk such as pitch, stress and volume (Fetterman, 1998).

The quantitative phase of the project has partly been informed by a interpretative method of enquiry but a deductive approach to the analysis has been employed which makes assumptions about the ability to make statistical comparisons across data sets and generalisability of the study results to the wider research population. In this study, the types of cues and concern and type of missed or positive responses were categorised into pre-existing coding categories which were then statistically analysed in order to make comparisons across groups. A quantitative and therefore deductive approach to the analysis also makes assumptions about the causal relationships between variables (Bergman, 2008). This is evidenced in this phase of the study which seeks to identify what demographic variables (age and gender of prescriber and



consultation length) influence the type of prescriber response to patients' emotional cues and concerns. This phase of the study collected observational data comprising audio recordings of consultations between GP, nurse and pharmacist prescribers and their patients. The recordings were then coded using a synthesised coding framework developed and adapted for use in this study. Frequencies were carried out on the categorisation of the type of patient cue and concern and type of prescriber response while a statistical analysis was employed to compare the positive and missed prescriber responses across the three groups (GPs, nurse and pharmacist prescribers).

## **Phase One**

### **3.6 Aims and Objectives of Phase One**

#### **Aim**

To compare the nature and frequency of patient's cues and concerns and GPs, nurse prescribers (NPs) and pharmacist prescribers (PhPs) responses to them.

#### **Objectives**

- (1) To identify the frequency and nature of cues that arise within patient-prescriber consultations
- (2) To identify whether different prescribers respond differently to patient cues
- (3) To identify what demographic variables (for example, age and gender of prescriber and consultation length) influence the type of prescriber response to patients' emotional cues and concerns

#### **3.6. 1 Development of the Cue-Response Tool**

The starting point for the development of the coding framework was the Levinson paper (2000) from which five further versions were developed based on a need to revise and adapt the original coding framework following extensive

piloting. Each version developed from a discussion with the second coder (JP) and the principal investigator (MW) in which gaps in the coding categories were discussed. Thus, the coding framework was developed iteratively, in response to piloting the framework on a sub-sample of audio recordings and through discussion between JP and myself in order to develop a coding system which accurately captured the nature of patients' cues and prescriber responses.

The first version of the coding sheet (see figure 5) was based on the paper by Levinson et al. (2000) who set out to compare the empathic responses of GPs and surgeons to patient's 'clues' in medical consultations where clues were defined as 'a direct or indirect comments that provide information on any aspect of a patient's life circumstances or feelings' (Levinson et al., 2000:1022). Version 1, based on the Levinson paper, distinguished between emotional and social clues, whether they were direct or indirect, and whether those clues were patient or prescriber initiated.

The clues were written down verbatim and were distinguished in terms of the type of clue they referred to. Each clue expressed by patients within their 'turn' was coded as a separate clue. A 'turn' can be described as when a participant has naturally completed their turn in the conversation and is often indicated by verbal or prosodic cues such as changes in pitch, volume or silence (Nofsinger, 1991). In figure 5 there is a section of the coding sheet which includes the categories employed to describe the type of clue and type of positive or missed response. The researchers also noted down, how many times the patient raised the same concern again if the original clue was missed by their healthcare professional. The decision to include this was based on the finding by Levinson that if patient clues were missed, they raised them again during the consultation.

The prescriber's response to the patient's emotional clues were also written down verbatim. In terms of the type of responses to clues, positive responses were defined as those responses which encouraged the patient to express their personal, psychological or family-related concerns while missed responses were coded as missed when a prescriber did not support or encourage the patient to discuss their emotional concerns, or when they avoided the subject (Levinson, 2000).

Levinson categorised and defined the types of positive and missed responses as:

Type of Positive Response:

- Acknowledgement - 'when the physician names the patient's feelings or acknowledges the concern'
- Encouragement, Praise or Reassurance - 'when the physician offers encouragement, praise or reassurance to patients' concern'
- Supportive - 'when the physician is supportive of patient's concern'

Type of Missed Response:

- Inadequate acknowledgement - 'when the physician responds to patient's clue but does not refer to underlying concerns'
- Inappropriate humour - 'when the physician laughs or jokes inappropriately'
- Denial - 'when the physician denies patient's concerns'
- Terminator - 'when the physician terminates discussion of emotion'

Figure 5: Section of coding sheet, version 1.

More Detail about Clue (verbatim quote)	
<i>Emotional:</i> (1)feelings about biomedical condition e.g. frustration, guilt, denial, fear (2) Aging (3) Stress e.g. work, other global life concerns (4) Bereavement (5) Concerns about life changes e.g. last child to go to college, wife in nursing home, retirement (6) Other	
<i>Social:</i> (Prescriber can learn more about patient's life e.g. information about sports, weather, holidays) (verbatim quote)	
Physician Response to Clue ( <b>verbatim quote</b> )	
Positive Response:	Missed Opportunity:

Acknowledgement _____	Inadequate Acknowledgement ____
Encouragement, Praise or Reassurance _____	Inappropriate humour _____
Supportive _____	Denial _____
	Terminator _____
	Re-direction _____
	If clue is missed, how many times does the patient subsequently mention the concern? _____

In the next version of the coding sheet, version 2, (Appendix H) the study team incorporated the category 'valence' to identify whether patient's cues and concerns were positively or negatively phrased, a term described in the Empathic Communication Coding System (ECCS) developed by Bylund and Makoul (2005). In their study, Bylund and Makoul coded for valence or whether a cue/concern was phrased positively or negatively based on the interpretation of facial expressions (which we did not have access to) and non-verbal cues or prosodic cues described earlier by Nofsinger (1991) as changes in pitch or volume. In the second version of the coding sheet an additional category of 'medication' was added to the type of clue which related to any medication type clue raised by the patient. This included, for example, side effects of medication, or when patients questioned the efficacy of their treatment.

For version 2, the coding team also added 'pursuit' to the categories of positive responses as it was felt that the category 'acknowledgement' did not do justice to those responses which followed up or pursued patients' cues or concerns. I employed the term pursuit based on the definition in Bylund and Makoul's ECCS (2005) who defined pursuit as when the professional 'explicitly responded to the central issue' in the concerns and when the concern is 'followed up by exploring/clarifying feelings about a patient's cues/concerns or by encouraging the patient to talk more about their thoughts, feelings or beliefs about the cue/concern.'

For version 2, the form was further revised to include a category to the type of missed responses called 're-direction' which was a term employed by Marvel et al. (1999) in her paper on the opening solicitation of the consultation and whether or not the patient completed their agenda (the reason(s) for the patient's visit). Marvel et al. used this term to refer to the way in which doctors diverted patients' agendas by asking a clinically driven question about their agenda item which prevented patients from completing their reason(s) for visiting. In this coding framework, the term was used to refer to professionals who re-directed their patients without offering a positive response. Examples of re-direction tended to include questions which were employed to gather clinical information for history taking purposes and diagnostic reasons e.g. 'when did it start?' or 'where does it hurt?' and this potentially interrupting the flow of the patient's narrative.

Version 3 (Appendix I) included one further category 'interruption' within the type of missed response category which was included as we identified instances of patients being unable to complete their clues or 'turn' because they were interrupted by their healthcare professional and when the interruption did not relate to their clue and was therefore not a 'pursuit'.

Version 4 (Appendix J) incorporated 'impact of illness' as a cue type category which related to how the patient's illness, condition or symptoms impacted on the patient's day-to-day life, for example, when a patient's asthma or breathlessness impacted on their activity levels or if a patient was experiencing difficulties sleeping which therefore impacted on their energy levels.

This version also dispensed with the term valence as it was considered too difficult to judge based solely on audio recordings alone. The Bylund and Makoul (2005) coders could rely on videotape which would have facilitated the process of identifying whether patient's clues were communicated positively or negatively. It was also felt that having this category did not add to the overall aims and objectives of the study.

The development of the final version of the coding framework, version 5, (Appendix K) was devised in response to the publication of the Verona Coding

Definitions of Emotional Sequences- VR-CODES – (Del Piccolo et al., 2009). The VR-CODES manual included a more detailed definition of the term cue and concern which was then adopted to replace the term 'clue'. The definition of cue and concern can be seen in Box 1 and was added to the bottom of the coding sheet to assist both coders in identifying and differentiating cues and concerns.

Box 1: Definitions of cue and concern (From VR-CODES - Del Piccolo et al., 2009)

**Cue** - 'Any expression introducing new contents by variations in voice quality, content, or speech and indicating that in the consultation there is still something not explored or not dealt with enough. Refers to expectations, ideas, feelings, symptoms, somatic or emotional worries experienced by the patient

**Concern** - 'A clear/direct and unambiguous expression of an unpleasant current or recent emotion'

(Del Piccolo et al., 2009)

The final version also collected basic demographic information on the patient and professional's gender, identified the timing of the cue/concern for reference purposes. The final version also dispensed with the social category as we felt, the aims and objectives of the study focused on patient's emotional cues and therefore an inclusion of social cues distracted from the focus of the study. Furthermore, this category was also omitted because it occurred infrequently. An additional change to the final version related to adaptations to the type of positive and missed response categories based on the low frequency of responses such as inappropriate humour and denial. It was decided that in addition to inadequate acknowledgement, re-direction and interrupting, a fourth category termed 'other' would incorporate other less frequently coded categories such as inappropriate humour and denial. The positive response category 'supportive' was amalgamated into the existing category 'praise and encouragement' due to the low frequency of responses identified for this category.

The final change was an inclusion of a space which invited coders to write down their 'impressions of the consultations' which provided a brief description reflecting the impression of the consultation on the coder in terms of empathic communication. It was felt that by solely focusing on the cue-response sequence, the coder does not have the opportunity to capture their overall impression of the consultation in terms of how well professionals responded to a patient's lifeworld cues and concerns. This qualitative element on the coding sheet, was also helpful in the sampling process for the qualitative phase since it enabled identification of consultations in which professionals' responses were ambiguous or were challenging to code using the framework. For example, this included biomedical redirections which were intended to be supportive or consultations in which the professional appeared to offer the patient space to talk but did not always respond 'positively' to their cues and concerns. The final coding sheet (version 6) is presented in Appendix L and represents a framework which was adapted for our data set following an iterative process of reflection, piloting, discussion and agreement amongst the team. The development and piloting of the coding framework took place over a period of 6 months. As a result, some audio-recorded consultations coded in the early stages had to be recoded using the final version of the coding sheet.

In order to enhance intercoder-reliability, coding guidance was developed (Appendix M) which both coders could refer to in order to assist in the coding process. We also had regular meetings in order to discuss any difficulties we had in coding which was particularly helpful given the inherent challenges of employing an interpretive coding process. These challenges will be discussed in greater detail in the following section 3.6.3.

### **3.6.2 Internal validity - Inter Coder Reliability**

The second coder (JP) and I met regularly and with the principal investigator to discuss differences, ambiguities and any difficulties in the coding process. To assess inter coder reliability, coder 2 (JP) selected a random sample of 10 consultations originally coded by coder 1 (RR). Using a standardised positive agreement formula as referred to by Syklo<sup>5</sup> (2007), the mean positive agreement between coder 1 and 2 was calculated at 65% with a median of 70%

which is regarded as a 'good' level of agreement between researchers (Syklo, 2007). Appendix N shows the full inter coder positive agreement results for all 10 consultations.

### **3.7 Processing and Analysing the Data for Phase One**

#### **3.7.1 Processing the Data**

The data collection and coding of data for the quantitative phase were run concurrently. Data recorded on the coding sheet was entered into an SPSS database which was designed and set-up by myself. The unique identifying code per recorded consultation was entered alongside nominal variables for prescriber type, prescriber gender and patient gender while prescriber age, length of consultation, number of cues expressed and numbers of positive and missed response were entered as continuous data in SPSS. Further nominal categories were entered for type of cue and type of missed or positive response.

The data was subsequently cleaned for data errors which involved checking for missing entries, outlying values, and typographical errors (Pallant, 2010). Secondly, a sample of cases from the full data set were randomly selected in order to check for coding errors. Next, errors for categorical data were identified by checking frequencies and looking for minimum and maximum values and valid entries.

Finally, the proportion of missed and positive responses were calculated by computing a new variable which calculated the proportion of positive and missed responses as a percentage of the total number of cues and concerns expressed per consultation.



### **3.7.2 Analysing Data for Phase 1**

#### **3.7.2.1 Descriptive Analysis**

Once the data was cleaned, descriptive analyses were then undertaken to describe the patient/prescriber demographic information across the prescriber groups and to identify the types of cues raised by the patient and the nature of prescriber responses (type of positive or missed).

#### **3.7.2.2 Assessing the Normality of Data**

Analyses were undertaken to obtain descriptive statistics on the dependent variables (proportion of positive/missed responses) which included means, standard deviations, skewness, kurtosis, tests of normality using the Kolmogorov-Smirnov statistic in order to ascertain whether the data violates assumptions about the use of parametric or non-parametric tests. In other words, the data was assessed to identify whether it was normally distributed (Pallant, 2010). These results are presented in chapter 4.

#### **3.7.2.3 Parametric and Non-Parametric Tests**

The skewness tests showed that the data were not normally distributed and therefore the use of non-parametric tests were employed in comparing the missed and positive responses of professionals across the prescribing groups. Kruskal- Wallis and Mann-Whitney U tests were used to make a statistical comparison of responses across the three prescribing groups. The analysis also examined the impact of prescriber gender on the proportion of positive responses to patient cues and concerns using the Mann-Whitney U test while a Spearman's rho for non-parametric data was used to ascertain the effect of age of prescriber and length of consultation on the proportion of missed and positive responses. The exception to the use of non-parametric tests was the use of one-way Analysis of Variance (ANOVA) to explore the impact of prescriber group on

consultation length since this was considered to be normally distributed. The results of the descriptive analysis and statistical tests are found in chapter 4.

The next section will present the qualitative method employed in the study.

## **3.8 Phase 2**

The purpose of the first section is to explain the guiding research philosophy underpinning the qualitative analysis and theory employed in the qualitative phase of this study. The following section will present the aims and objectives of the qualitative phase followed by a description of the method of sampling and a detailed description of the coding process and notes concerning transcription.

The final section will review the analytical process which includes a discussion on issues around the researcher's relationship to the data and a reflexive examination of my interest in the study phenomena and other factors which may have influenced the process of data collection, analysis and interpretation.

### **3.8.1 Inclusion of a Qualitative Phase**

As discussed earlier on in this chapter, the decision to include a qualitative analytic phase in this study was influenced whilst undertaking the coding for phase one, as discussed earlier in this chapter. Specifically, inclusion of a qualitative approach has allowed for a more detailed analysis of emotion management within the healthcare encounter and to explore the facilitators and barriers to the employment of emotional labour.

An interpretivist approach acknowledges that interpreting data employs our subjective selves and recognises that ways of understanding the world are bound up in our experiential knowledge and that these experiences can potentially influence ways of viewing/understanding the world and our data. This phase was interested in how professionals manage patients' emotions/feelings and the facilitators and barriers to doing so. This focus of enquiry is underpinned

by a paradigm shift in the understanding of health and illness which was critical of the biomedical model and science or positivism's 'irrational passion for a dispassionate reality' (Rieff, 1979). An interpretative epistemology acknowledges that people experience the world with both body and mind while challenging dominant claims to knowledge and supporting less privileged or subordinated voices (Kralik & van Loon, 2008) and is therefore an appropriate method of inquiry as it rejects claims to objectivity in the social sciences and sciences.

### **3.8.2 Ontological Assumptions**

The theory of emotion work/emotional labour and related explanatory frameworks are underpinned by the ontological assumptions of social constructionism (Fineman, 2003) which takes an interest in how people interpret their world and make sense of their reality through the exchange of meanings (Burr, 1995). Social constructionists argue that the ways in which people interpret their world are influenced by the social and cultural mores surrounding them and thus explains cultural/social variations in the understanding of social phenomena (Burr, 1995).

A social constructionist perspective of emotional labour argues that individuals' social realities, meanings, knowledge, ways of interpreting and understanding their emotional worlds are largely mediated through social and cultural heuristics or rules. It is therefore argued that these rules influence what emotion displays and expressions are acceptable in any given social/cultural context. Social constructionists argue that how an individuals' reality is understood at any given point in time is influenced by communication conventions which are socially, culturally and historically contingent. For example, the way in which people communicate their biopsychosocial worlds or emotional selves are largely determined by the language or discourses available to them at a given point in time and conventions which dictate what can and cannot be communicated (Fineman, 1983).

In the context of this study, what is expressed and managed within the healthcare encounter as a dynamic social encounter are likely to be influenced by both the socio-cultural feeling rules of patient and professional. Of relevance to this study is how the professionals' feeling rules are influenced by multifaceted socio-cultural heuristics operating at a personal, professional and institutional level. For example the gender of the professional may be a factor in terms of the gendered aspects of emotional labour or the social-cultural mores implicit or explicit in the professionals' training may contribute to the construction of feelings and the way they are managed.

A sociological account of emotions depicting the social constructionist influences of emotions/feelings were discussed earlier in Chapter 2 and refer to the way in which 'conscious' embodied emotions become enacted and shaped within a socio-cultural framework. In the context of emotionality and the ways feelings are communicated and managed within social interaction, including interactions within a healthcare encounter, a social constructionist standpoint would posit that emotion rules are mutable. In other words, they are not fixed or static but are dynamic, flexible and adapt to any given context and expectations about what is (in)appropriate within any given situation/context. Fineman (1983) referred to heuristically governed emotion displays as 'emotion scripts' which he defines as 'ways of expressing our feelings that are already inscribed into the language...and define the way people are able to talk about their feelings' (Fineman, 2003: 20).

The dynamic and relational elements underpinning the social construction of emotions also dictates that emotion displays and what is communicated occurs within a dynamic and relational context in which interactants respond to others' emotional expressions based on recognisable socially constructed rules (Fineman, 1983). This echoes Goffman's reference to roles and performances which he argued are largely influenced by previous encounters and the way we use and re-deploy social and cultural scripts used in previous interactions in order to present a socially acceptable image of ourselves, as discussed previously in Chapter 2 (Erikson, 2004). Therefore, when we communicate our feelings, they are not only governed by social and cultural 'rules' but are also influenced by how we wish to present ourselves to others. As Goffman argued, how individuals present their selves and rules directing impression management

are principally driven by the desire to present an acceptable self-image and interest in avoiding shame (Goffman, 1959).

In adopting a social constructionist viewpoint and influence of socially constructed feeling rules governing what we express and how we manage emotions, it allows for a critical interpretation of the ways in which patients' emotionality is expressed and managed within the healthcare encounter.

The study has drawn upon emotion work theory to understand and capture the 'work' involved in emotion management, particularly within the health service sector. As discussed in previously in chapter two, emotion work theory has recently been tested and adapted for its application within a healthcare context (for example, Smith, 2012; Theodosius, 2008; Bolton, 2000). The application of emotion work theory to the primary care setting will also be considered when undertaking the qualitative analysis. The application of emotional labour theory within a health care setting also acknowledges the interplay of sociological factors such as how the gender, professional status or identity of particular professionals may intercede in the way that patients' emotions are managed. The analysis will also consider the ways in which macro level processes such as the wider institutional or political context may influence healthcare professionals' delivery of emotional labour. Finally the analysis will also consider the gendered aspect of emotional labour and to what extent this may be a factor in the employment of emotional labour in consultations recorded for this study.

### **3.8.3 Aims & Objectives**

1. Understand the ways in which GPs, nurse and pharmacist prescribers employ emotional labour within the context of a healthcare encounter
2. Identify the facilitators and barriers to the employment of positive emotional labour within healthcare encounters between patients, GPs, nurses and pharmacists
3. To understand how the sociological context (institution, gender, professional) influences the management of patients' emotional cues and concerns gap

### **3.9 Method**

Several studies on emotion work have employed an ethnographic approach to observing emotion work in various settings (Theodosius, 2008; Hochschild, 2003) while other studies have analysed taped interviews with participants (e.g. Buzzanell & Turner, 2003; Barry et al., 2000; Heath, 1998). This study has utilised a non-participant observational method of data collection employed by the Leverhulme study. Recording consultations in this way has been recognised as an acceptable and viable way of capturing talk in its natural setting (Silverman, 2006). I have therefore argued that audio-recording consultations between patients and GPs, nurses or pharmacists within a primary care setting is also a viable and acceptable method of capturing the emotion communication and management of emotions by healthcare professionals employed within the context of a healthcare encounter.

One potential drawback of this method could be that I have not utilised other qualitative approaches to data collection which could have provided further insight into the practice of emotion work (interviews, diaries, visual ethnography, a case study approach). However, due to the constraints of this study in terms of time and space, it was decided that observations from audio-recorded consultations within their naturalistic settings have generated sufficiently rich data to enable examination of the communication of emotions within the health encounter in sufficient depth.

#### **3.9.1 Method of Sampling the Audio Recordings**

From the original 528 audio recorded consultations recorded and analysed for the quantitative phase of the study, a qualitative analysis was undertaken with a purposive sub-sample of thirty transcribed consultations, comprising ten

consultations per prescribing group. The thirty transcribed recordings were selected from a pool of 100 recordings that had been previously been partially or fully transcribed for a separate, discrete study undertaken by a conversation analyst.

Given the in-depth scrutiny employed in the analysis of the thirty transcribed audio-recordings, it was considered that the 30 transcribed recordings of audio recorded consultations were sufficient to address the aims of this phase. A similar study employing a mixed method approach to study emotion work in healthcare encounters analysed a similar number of recordings for the qualitative phase (Baker et al., 1996). Additionally, the depth of analysis is considered an important factor in the credibility of findings from qualitative analysis rather than the sample size alone. It is argued that the aim of qualitative research is not to obtain a representative sample but to analyse in sufficient depth and to make this process transparent (Bryman, 2012). The method employed for the purposive sampling of the 30 consultations is described next.

Firstly, a range of recordings were selected based on the varying level of missed opportunities and positive responses identified in phase 1. I included consultations that had a high frequency of either missed or positive responses and those that had a mixture of both missed and positive responses across GP, nurse and pharmacist prescriber consultations.

The rationale for including the selected 30 consultations for qualitative analysis is summarised in Table 3. A more detailed table describing the rationale is provided in Appendix O which also provides information about the type of consultation (such as medication review or open clinic), the proportion of missed and positive responses by professionals as identified in the quantitative phase; and consultations or cue-responses which were considered difficult to code using the phase one framework discussed previously.

Table 3: Table Summarising Consultations Included for Qualitative Analysis

Professional Group	Study ID	Reasons for Inclusion in Qualitative Analysis
General Practitioners (GPs)	115	The GP overlooks the patient's concerns about an on-going infection. Consultation hurried and frequent typing.
	171	The GP is concerned that the patient may become addicted to sleeping tablets yet does not always acknowledge its impact on the patient nor enquire about why she is not sleeping.
	252	The doctor overlooks the patient's cues and concerns about the medication side effects and by sticking to the clinical script.
	650	The doctor does not consistently attend to the patient's psychosocial concerns which cause her sleeplessness and impacted on her eczema. Frequent typing.
	295	The GP is attentive and empathetic to the patient's cues/concerns .



Professional Group	Study ID	Reasons for Inclusion in Qualitative Analysis
	63	The doctor does not explore the possible psychosocial reasons underlying the patient's drinking behaviour but rather appears more focused on quantifying how many units of alcohol she consumes.
	213	GP responds empathically to the patient and conveys understanding of the impact of not sleeping on the patient's day-to-day life but overlooks a few c/c.
	313	The doctor is very empathic and is slightly reluctant to prescribe another course of antibiotics but involves the patient in the process and explains what her options are and is also very responsive and sympathetic to how unwell she feels.
	454	The GP goes some distance to reassure the patient but does not explicitly acknowledge her real concern and audible distress about having a suspected benign tumour.
	281	This GP is task focused and very clinical and therefore patient's c/c

Professional Group	Study ID	Reasons for Inclusion in Qualitative Analysis
		ignored/overlooked.
Nurse Prescribers	977	The nurse is sympathetic but does not always acknowledge the patient's cues and occasionally interrupts the patient's narrative with biomedical questions. Frequent typing.
	92	The nurse appears to be very focused on adhering to the script and pro forma of a medication review and so is inattentive to the patients' cues and concerns relating to the patient's health problems.
	138	The nurse listens and responds empathically and provides the patient with space to talk. Sounds slightly rushed.
	808	The nurse gives ample space for the patient's narrative and is empathic and acknowledges his cues and concerns with some exceptions.
	553	The nurse is largely sympathetic but not always empathic – sticks to her script.
	236	The nurse appears very task focused and addresses the patient's biomedical concerns without attending to or acknowledging the patients psychosocial concerns or offering any reassurance to the patient's underlying worries about whether or not

Professional Group	Study ID	Reasons for Inclusion in Qualitative Analysis
		she has swine flu.
	474	The nurse's empathic response reflects that the nurse is capable of going 'off script' and doesn't always adhere to her clinical asthma/QoF box template.
	194	The nurse is generally sympathetic but tends to stick to her script – her responses seems minimal and distracted.
	632	Although the nurse appears sympathetic in her responses, the responses sound unconvincing. Cues overlooked.
	745	The nurse responds off-script but, at times, the consultation feels a bit rushed, giving little space for the patient to talk/participate.
Pharmacist Prescribers	848	The pharmacist attended well to the patient's life world concerns but occasionally responded within a biomedical framework/script.
	862	The consultation is very formulaic with the pharmacist stringently following a biomedical script with little opportunity for the patient to participate.

Professional Group	Study ID	Reasons for Inclusion in Qualitative Analysis
	942	The pharmacist strikes the balance between delivering her own agenda and meeting the patient's. Improvises and is responsive to her patient.
	341	A very script run consultation – little off script work, particularly in response to the patients' c/c. Little opportunity for the patient to participate.
	1050	The pharmacist sticks to the script – her medication review template which forecloses any opportunity for the patient to participate.
	962	The pharmacist sticks to the script – her medication review template which forecloses any opportunity.
	928	The pharmacist provides the patient with space in the consultation to talk through his other health conditions which may impact on the blood pressure. Responsive

Professional Group	Study ID	Reasons for Inclusion in Qualitative Analysis
		and empathic.
	358	Very script drive and little opportunity for the patient to participate. C/C often overlooked.
	1098	The pharmacist provides space in the consultation and appears attentive to her patient.
	593	The pharmacist is able to improvise and is responsive to her patient's needs.

### **3.9.1.1 Transcription Methods for Qualitative Analysis**

The majority of the bank of 100 consultations previously partly or fully transcribed by a conversation analyst (SC) in accordance with conversational analysis transcription conventions described by Heritage (1984). See Appendix P for a detailed notation index. It has been argued that employing recognised transcription conventions increases the trustworthiness of the data as it enables a more detailed and accurate method of recording the detailed interactional features of talk such as overlapping speech or hesitations (Seale & Silverman, 1997).

### **3.9.2 Analysis**

The following section will describe the process of preparing the data for analysis and the approach employed in coding and analysing the data.

#### **3.9.2.1 Data Preparation**

All names were replaced with pseudonyms and any information which could potentially identify patient, professional or practice were removed or anonymised e.g. patient/professional references to place names or names of other persons. While the NVIVO software package was considered to facilitate coding, analysis of the qualitative data was undertaken 'by hand' using a hard copy of the transcription. This was influenced by a personal preference for reading and annotating on a hard copy transcript rather than an electronic version.

### 3.9.2.2 The Coding Process

For the qualitative analysis, an analytic reasoning process informed by adaptive theory (Layder, 1998) was employed. Adaptive theory adopts a middle ground between a hypothetico-deductive approach and an inductive approach employed in the techniques of grounded theory (Strauss and Corbin, 1990). Adaptive theory recognises that while it is important to allow generation of theory from the data, existing ideas, knowledge, experiences and feelings can intercede and inform the way in which emergent theory is shaped. In this way, adaptive theory represents a pragmatic approach to the realities of the research process and data analysis and in this way complements the social constructionist ontological assumptions of this research which acknowledge the social and cultural influences in the construction of knowledge (Layder, 1998).

Adaptive theory proposes that the process of coding the data, labelling the data and in the more conceptual phases of data analysis are, to some extent, informed by what we already know. Pre-existing knowledge (derived from cognitive and emotional sensing) may include influences from the existing literature, one's experiential knowledge, epistemological and an individual's ontological assumptions about the subject area or wider social world.

In this respect, I have drawn on a body of literature to inform my analysis of the data. For example, I have drawn upon the following theoretical traditions and also literature within a patient centred framework to inform my analysis. Although not exclusively, it is likely that the following theories and areas of literature would have influenced my analytic process:

- Emotion work theory and emotion management within a healthcare context
- Traditions informed by Goffman in relation to understanding emotional expressivity in the presenting self (Baker et al., 1996; Goffman, 1957). This also utilises the literature presented under the heading of how and why patients communicate emotions in the healthcare encounter.
- Traditions informed by a person-centred, Rogerian (1951) approach to counselling and therapy in which the individual's needs, concerns, ideas,

feelings beliefs etc are placed at the centre of the consultation and in which the therapist employs empathy (amongst other approaches) as a therapeutic approach (links to patient centred approach).

- The presented literature on how patients want their healthcare professionals to communicate as a framework for approaches to managing patients' biopsychosocial worlds, including their emotional cues and concerns in the consultation. With respect to patient preferences for professionals' communication skills, I drew upon three key studies (Deledda et al., 2013; Mazzi et al., 2013; and Bensing et al., 2011) and created a checklist of patient/lay informed preferences for communication skills. This checklist can found in Appendix Q
- Evidence underpinning the clinical and psychotherapeutic benefits of employing a patient centred and empathic approach to healthcare

During the qualitative analytical process, I have also consciously given space to emerging aspects, nuances and themes within the consultation which were not included in the first phase. It was important to search out and identify those nuances which elucidate our understanding of emotion management. For example, in terms of emotion management, I identified ways in which GPs, nurses and pharmacists create space and opportunities within the consultation process, albeit directly or indirectly, which may enable patients to voice concerns. It was also important to be attentive to contextual differences within the consultation which may give rise to particular expressions of emotions or ways of managing emotions. The analytic process was also mindful of different types of consultations, for example consultations for acute or chronic conditions, medication reviews and whether or not they had an influence on the employment of emotion work by professionals. Importantly, attention was paid to the three professional groups and whether any approaches to the management of emotions could have been attributed to the professional group rather than individual differences.



### **3.9.2.3 Evaluating the qualitative research**

Guba and Lincoln (1994) refer to trustworthiness and authenticity as two principle criteria for assessing qualitative research. Using their definitions and criteria, I will assess my own approach to the research process including the analysis and interpretation of qualitative data.

### **3.9.2.4 Trustworthiness of the Data**

To examine the trustworthiness of the data, I have drawn upon the following criteria: credibility, transferability, and confirmability (Guba and Lincoln, 1994) and will examine each in turn in relation to this research.

### **3.9.2.5 Credibility**

To address issues around the trustworthiness and credibility of the analytic process and claims that I have made about the data and the interpretation of findings, I have endeavoured to describe in detail the approach to the analytic process which I have undertaken. The approach to data analysis and interpretation of the findings were subject to a systematic and rigorous process as described previously in this section. Guba and Lincoln describe various techniques to ensure that inferences made about the study phenomena are credible. I have incorporated these and similar techniques into the research process which are discussed below.

### ***Triangulation***

In this study, triangulation refers to approaches for generating rich, comprehensive and robust accounts of the study phenomenon which aim to deepen understanding. This study has drawn upon three types of triangulation identified by Denzin (1978) and Patton (1999):

### *Analyst Triangulation or Member Validation*

Member validation is a process of checking out or inviting others' interpretations of one's first order (codes or themes generated from raw data) and second order constructs (interpretive findings) as outlined by Schutz (1967). This process of member validation was conducted at different stages of the analytic process and are outlined as follows:

Firstly, I invited opinions on and interpretations of the data from other social scientists based in the Critical Research in Social Psychology Research (CRISP) group at Bath University. After presenting the principal theories underpinning my Research, I presented excerpts of the data to this peer group. This research group represented a range of social scientists from different disciplinary backgrounds and theoretical orientations at varying stages in their careers. This process enabled me to critically reflect upon my own interpretations of the data while incorporating others' views and reactions to the data.

#### **Member Validation: An Example of Peer Reflection**

A member of the CRISP group (DR) offered to send her thoughts and reflections on one transcript after I presented some initial findings and has kindly given her permission for me to use her reflections here.

Reflections on nurse prescriber consultation 236:

"What I got from this was that the old lady was expressing her anxiety that the infection she had, was something very serious, like swine flu and she mentioned probiotic yoghurt, almost testing the nurse, to see her reaction and the nurse agreed with her that it was good.

The nurse, again like the first case, seemed to be going through a mental script - checking symptoms, doing an intervention (showing her how to use the inhaler), and did seem to try and give a little bit of reassurance, but she did not explore or probe any deeper, she may have been aware that the old lady was very anxious, but she did not make any attempt to reflect back to her, so not

much listening going on. Reflecting back, and paraphrasing are key indications that someone is actually listening. This may be useful for you in your analysis (or not !)" (DR)

Secondly, when the analytic process was more advanced, I invited the opinions of peers for their views on the credibility of the study findings and whether they were confident that the claims made were supported by the findings.

Thirdly, I invited comments and discussion about the theoretical and clinical implications of the study findings. I presented my qualitative findings to the qualitative research group in the Department of Social and Community Medicine at Bristol University where I am currently employed. Again, this provided a platform for me to present my findings and to receive comments and ideas from a peer group of multidisciplinary social science researchers and academics (i.e. anthropologists, sociologists, psychologists) with multi-professional backgrounds (i.e. nursing, medicine, psychology and counselling). This process in which I invited the opinions on the viability of claims made and the extent to which this was supported by the data was helpful and served to both validate claims and question them. Additionally, due to the multi-disciplinary background of attendees, I invited a discussion on the theoretical and clinical implications of the findings for patients and professionals and how the findings relate to future support and training needs for the professionals.

This proved helpful, as I had some useful comments from a GP in training who informed me that GPs feel unsupported in their role and 'burdened' by the different demands of general practice, not least in having to manage QOF and other bureaucratic demands. The most poignant reflection was of one of his colleagues who felt overwhelmed and stressed and, in contrast to their experience of medical training where they had designated support groups comprising other medics, there is little support on offer in primary care. He told me about a new initiative being promoted by the Royal College of General Practitioners which aims to provide more support to GPs. This peer-peer support group is discussed further in chapter 6.

I reflected on this doctor's insight yet in the back of my mind my thoughts were also with other healthcare professionals in primary care, principally nurses and I

wondered how they were coping and why their voices were not being heard – to what extent did this reflect the dominant voice of medicine?

### *Method Triangulation*

As discussed earlier in this chapter in section 3.2 'A Mixed Method Approach', the rationale for employing two methods of analysis in phase one and two was its usefulness in elucidating different facets of the study phenomenon. By drawing upon the findings from both phases, it has strengthened the credibility of the findings and provided deeper understanding of the study phenomenon. The conclusions drawn from the triangulated data are presented and discussed in Chapter 6.

### *Theoretical Triangulation*

The use of different theoretical perspectives has been identified as a useful technique for examining and interpreting the data (Denzin, 1978; Patton, 1999). This applies to both phases as highlighted in section 3.9.2.2 which acknowledges and outlines the key theoretical influences on the research process and, in particular, on the data analysis.

### *Negative Case Analysis.*

Whilst carrying testing categories in the coding phase as outlined by Bryman and Burgess (1994) in which emergent categories are checked against existing categories and data, particular attention was paid to examples in the data which may have refuted or did not 'fit' with emergent categories – these are referred to as negative cases.

## ***Transferability***

Transferability refers to the ways in which the study findings can be transferred to other contexts. One way of maximising the transferability of findings is through the provision of detailed contextual information in relation to the data in what *Guba and Lincoln (1994)* describe as '*thick description*'. In this regard, detailed contextual information relating to the consultation is provided throughout the qualitative findings. Detailed information describing the following contextual features are found in Appendix O - the location of the practice, the type of clinic, type of prescriber, prescriber age/gender, patient gender, and contextual information about the consultation (patient's stated reasons for visiting).

## ***Confirmability/Reflexivity***

Interpretive research acknowledges the role of the researcher in the process. This approach to research acknowledges that the values of the researcher can 'intrude' on the research process at any juncture, for example in the choice of research area, research questions or in the interpretation of data and conclusions drawn (Bryman, 2012).

In terms of elucidating my perceived role in the research process and to reflect upon how I may have impacted on the various stages of the research process, I maintained a diary to reflect upon these issues. Lynch refers to a commitment to undertake philosophical self-reflection/introspection and methodological self-consciousness and self-criticism (Lynch, 2000) and similarly I aimed to the same through my diary entries which are included throughout the qualitative findings section. This reflexive process has enabled me to examine the extent to which I have acted in good faith in terms of whether my values have influenced the research process. During this process, I have reflected on what experiences, concepts, values, expectations, preconceptions, I may have brought to the research process.

## *Authenticity*

Authenticity concerns the impact of the research findings on the wider community as defined by Guba and Lincoln (1994) in which they question how the research findings are representative of the social phenomena in other similar contexts and which Yardley (2000) also employs as criteria on which to assess the impact and importance of the research.

The social phenomena of cues and concerns has been widely reported in health care encounters in the existing literature (e.g. Zimmermann & Del Piccolo, 2007; Oz, 2001; Levinson, 2000) yet it has not been examined, to date, using the theory of emotion work to understand emotion management of patients' emotionality within a primary care setting. Additionally, there is a paucity of literature which specifically examines nurse and pharmacist prescribers' responses to patients' cues and concerns with the cues and concerns literature. Therefore the findings from this mixed method study can contribute to a wider understanding about emotion management from a theoretical perspective whilst focusing the lens on the emotional labour offered by GPs, nurses and pharmacists. The quantitative and qualitative findings have been used to inform a discussion section on the implications of the findings to the wider literature and theory development. In addition, the final chapter also considers the implications of these findings for patients and professionals and which lends credence to the usefulness of this work and ways in which it can contribute at a theoretical and applied level in terms of professionals' practice and potential implications for training and support needs.

I have provided a detailed description of the processes involved in the qualitative and quantitative phase of this study and have also provided a 'thick description' of the context (s) in which this study took place which will enable some tentative and cautious conclusions to be drawn and applied to similar settings.

Chapter 4 presents the results from the quantitative analysis while Chapter 5 presents the findings from the qualitative analysis.

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# Chapter 4: Quantitative Results

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## 4.0 Quantitative Results

This chapter reports the results from phase one of this study. The section will include the reported findings included in a published paper on which I am first author. The paper is included in Appendix P. The first section describes the characteristics of the study population including demographic information and information relating to the consultations of GPs, nurse and pharmacist prescribers.

The following section describes the nature and frequency of the type of cue or concern expressed by patients. The next section describes the process of assessing the normality and skewness of the data, specifically pertaining to prescribers' responses across the three groups. These tests were required to apply parametric or non-parametric tests in comparing responses across the groups and to inform decisions about which statistical tests were most appropriate to apply.

The subsequent section reports the results of descriptive and non-parametric tests relating to the type of response compared across the groups. The final section describes the findings from tests undertaken to ascertain to what extent demographic variables (age and gender of prescriber and consultation length) influence the type of prescriber response to patients' emotional cues and concerns. The chapter concludes with a discussion of the results and their implications for practice.

#### **4.1 Characteristics of Study Population**

Between October 2009 and September 2011, a total of 528 consultations were audio-recorded: 208 with GPs, 208 with nurses and 112 with pharmacists. These were from 51 professionals comprising: 20 GPs (8 female, 12 male) with a mean age of 49 (SD=5.4) years; 19 nurses (all female) with a mean age of 46 (SD=6.3) years; and 12 pharmacist (8 female, 4 male) with a mean age of 42 (SD=6.4) years. See Table 4 for a summary of or professionals' basic demographic information by professional group.

Table 4: Prescriber Demographics

<i>Prescriber Group</i>	<i>No of Prescribers (N)</i>	<i>Number of Consultations (N)</i>	<i>Age of Prescribers - years (M/SD)</i>	<i>Prescriber Gender % (N)</i>	
				<i>Male</i>	<i>Female</i>
GPs	20	208	49 (5.4)	60% (12)	40% (8)
NPs	19	208	46 (6.3)	0%	100% (19)
PhPs	12	112	42 (6.4)	25% (3)	75% (9)
ALL	42	528	46 (6.5) Min=42, Max=62	14% (15)	86% (36)

Prescribers were recruited from 36 practices across 14 Primary Care Trusts in southern England. Of the 36 practices, 19% (7/36) were situated in large urban populations, 25% (9/36) were situated in small-medium urban populations, 19% (7/36) in suburban locations, 22% (8/36) in town and fringe, 8% (3/36) in semi-rural areas while 6% (2/36) of practices were situated in rural locations.

The study included wide ranging consultations which included patients presenting with acute conditions (e.g. chest, throat, urinary infections, skin conditions etc.) and those with new or managed chronic conditions (e.g. hypertension, diabetes, asthma and cardiovascular conditions). The differing consultations may influence the type of cues and concerns expressed. For example, in a medication review, where the main focus of the consultation is likely to centre on the patient's medication and their condition, you may expect that a higher proportion of cues may relate to their medication, the effects of their medication (i.e. side effects) or discussions specifically related to the patients' management of their condition, for example discussion about lifestyle for patients diagnosed with diabetes, for instance.

Furthermore, if a patient is being managed for an ongoing condition by a particular prescriber, there may be evidence of an ongoing relationship and

greater familiarity which may have implications for the consultation process and interaction – although evidence related to familiarity of the professional on patient process and outcomes is inconclusive (Jabaaij, 2008). There may be additional influences in terms of the demands of QOF and how this may influence the consultation process, as highlighted by previously (cf Gillam et al., 2011; Mangin and Troop, 2007).

For acute illness presentation, there may be factors relating to a lack of familiarity with the healthcare professional or particular patient and professionals expectations relating to the consultation outcomes. As identified in the literature review (chapter two) such expectations are fraught with interactional difficulty.

Of the health care professionals, the 19 nurses completed their independent prescriber training at 9 different educational institutions while the 12 pharmacists undertook their training at 4 different institutions. The mean consultation length was 10.1 (SD=4.6) minutes for GPs, 11.2 (SD=6.5) minutes for nurse prescribers and 18.2 (SD=9.7) for pharmacist prescribers.

Table 5: Numbers of Consultation Recorded and Length of Consultation by Professional Group

<i>Prescriber Group</i>	<i>Number of Consultations (N)</i>	<i>Average Consultation Length (M/SD)</i>
GPs	208	10.1 (SD=4.6)
NPs	208	11.2 (SD=6.5)
PhPs	112	18.2 (SD=9.7)

Of the 528 participating patients, 34% (N=180) were male and 66% (N=348) were female with a higher frequency of male patients attending pharmacist prescriber appointments (48/112 – 43%) compared with nurse prescriber (64/208 – 31%) and GP appointments (69/208 – 33%).

For a full table of prescriber demographic information, refer to Appendix S.



A one-way Analysis of Variance (ANOVA) test was conducted to explore the impact of prescriber group on consultation length. The results show that pharmacist prescriber consultations were significantly longer than GP or Nurse Prescriber consultations:  $F(2,528)=56.7$ ;  $p<0.0001$ .

## 4.2 Patients' Cues and Concerns

The following sections employ descriptive statistics to describe the frequency and distribution of cues and concerns expressed by patients for each of the professional groups. The following section describes the types of cues and concerns expressed by patients and their distribution across the groups.

### 4.2.1 Frequency of Patients' Cues and Concerns

Of the 528 consultations, patients uttered an average of 3.4 (SD=2.6) cues and concerns in an average of 89% (N=470) of consultations across the professional groups.

Table 6: Average Consultation Length and Cues & Concerns by Prescriber Group

<i>Prescriber Group</i>	<i>Mean Consultation Length (SD)</i>	<i>Average number of Cues/ Concerns per Consultation (SD)</i>
GPs	10.1 (4.6)	3.7 (2.6)
NPs	11.2 (6.5)	3.3 (2.7)
PhPs	18.2 (9.7)	3.4 (2.7)
All	12.3 (7.4)	3.5 (2.7)

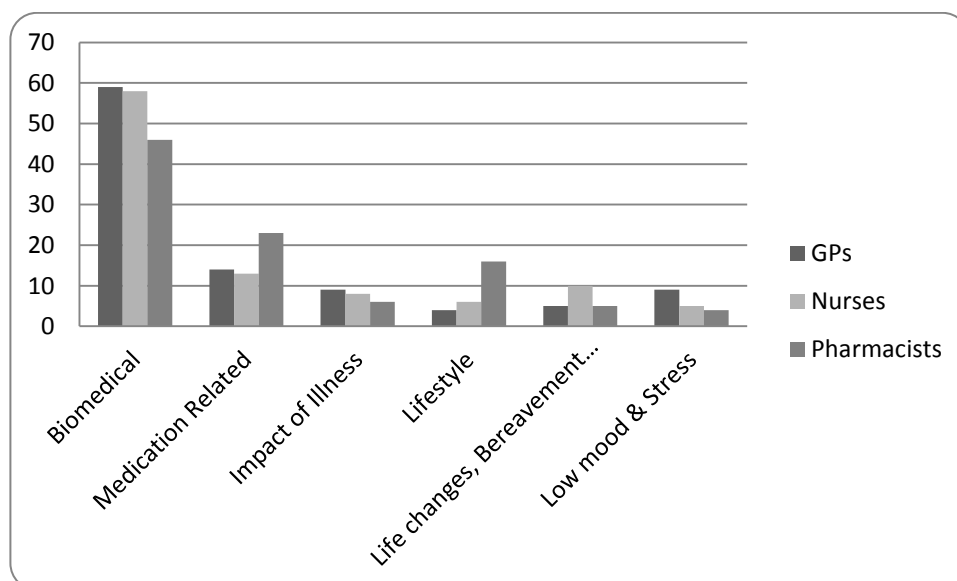
Using the non-parametric test for use with three or more groups, a Kruskal-Wallis Test was employed to ascertain whether there were differences in the mean number of cues and concerns presented across the prescriber groups. The test revealed that there were no significant differences in the number of cues and concerns presented by patients across the prescriber groups ( $p=0.1$ ,  $df=2$ ,  $\chi^2=3.2$ ). For all three groups the minimum and maximum number of cues and concerns ranged from 0 to 10.

Furthermore, a Spearman's rho ( $r$ ) was employed to ascertain whether there was a relationship between the consultation length and total number of cues and concerns expressed. The results of these tests revealed that the total number of cues and concerns expressed increased with consultation length (Spearman's  $r=0.31$ ,  $n=528$   $p<0.0001$ ).

#### 4.2.2 Type of Cue Content

The type of cues and concerns raised by patients, as a percentage of the total cues and concerns, is shown in figure 6.

Figure 6: Content of Patients' Cues and Concerns as a Percentage of Total Cue Content, by Professional Group.



Whilst entering the data into SPSS, it became clear that low mood or depression were categorised within the category 'feelings about a biomedical condition.' It was considered important to distinguish these range of feelings separately from feelings about a biomedical condition and therefore low mood, depression, anxiety, whether clinically labelled or lay defined were entered under the category of stress. Consequently, this category was redefined as low mood and stress and although arguably different, it ensured that feelings relating to depression or anxiety were distinguished from feelings relating to biomedical concerns.

Further changes were made at the end of data entry as it became apparent that few cues and concerns were categorised as bereavement and life changes and therefore a decision was made to amalgamate these categories under one heading titled 'life changes.'

Of the total cues and concerns expressed across GP consultations (N=760), nurse prescriber consultations (N=719) and pharmacist prescriber consultations (N=371), cues and concerns relating to biomedical concerns were the most frequent cue type across the three groups. Biomedical cues/concerns although occurred more frequently in both GP (59%, 450/760) and nurse (58%, 416/719) consultations compared with pharmacists' consultations (46%, 171/371). Biomedical cues and concerns related to the condition or symptom(s) which patients presented with or were being treated for is evidenced in the examples below.

### ***Examples of 'biomedical' cues/concerns***

GP Pt 702: 'Tuesday night, during the night, it [breathlessness] frightened the life out of me. I couldn't control my breathing...'

NP Pt 685: 'This is just really, really insane itching, and you can see how inflamed my eyes are.'

The second most frequent cue type uttered by patients was related to medication. The frequency was higher in pharmacist (23%, 86/371) consultations compared with GP (14%, 103/760) and nurse (13%, 92/719) consultations. As the examples below suggest, medication type cues and concerns related to concerns about side effects,

reluctance in taking medicines and concerns about the effectiveness of their treatment.

### **Examples of 'medication' cues/concerns**

GP Pt 806: 'Oh yeah, well, it's difficult, difficult to know really. I know the previous statin certainly gave me a lot of congestion on the chest, uhm, and I have a bit of congestion at the moment, whether that's the statin or not. The only way of finding that out is not to take it.'

PhP Pt 848: 'I've got lymphoedema and believe me, every day pains me but I try not to use them as an escape route. You know, I'll take some today but I may not take any tomorrow.'

The third most common cue type related to how a patient's medical condition or symptoms impacted on patients in their day-to-day life. The frequency of this cue type was similar in GP (9%, 71/760) and nurse (8%, 56/719) consultations compared with pharmacist's (6%, 22/371).

### **Examples of 'impact on daily life' cues/concerns**

PhP Pt 595: 'I can't walk as far as I'd like to walk. Since the fall, I can't even kneel on them.'

NP Pt 729: 'I'll lie awake at night scratching my arms, I can't sleep 'cause I'm scratching and scratching so much.'

GP Pt 171: 'Well sometimes I see every hour and I honestly think maybe I don't sleep at all until the last hour of the night.'

Other cue content related to cues and concerns about lifestyle were voiced more frequently by patients of pharmacists (16%, 61/371) compared to patients of nurses (6%, 42/719) or GPs (4%, 27/760) while content relating to life changes, ageing and bereavement occurred more frequently in nurse consultations (10%, 74/719) compared with both GP (5%, 37/760) and pharmacist consultations (5%, 17/371). Finally, content of cues and concerns related to stress and depression or

low mood was higher in those consultations with GPs (9%, 72/760) compared with patients of nurses (5%, 39/719) and pharmacists (4%, 14/371).

### **Examples of 'stress' related cues/concerns**

GP Pt 656: 'at the moment I'm living on my nerves.'

NP Pt 198: 'It's much to do with working too hard I should think and working my way through the flu...and not really, I wonder if I should have just signed off.'

### **4.3 Assessment of Data Distribution and Skewness: Prescribers' Responses**

In order to decide whether to apply parametric or non-parametric tests to the data to be able to make appropriate comparisons in prescriber responses using correlational tests, an assessment was undertaken to ascertain to what extent the data was normally distributed.

Firstly, the distribution of responses per professional group are depicted in the histograms (see Figures 7-9). A normal distribution is depicted by a bell shape curve which is not evident when applied to either of the histograms in Figures 7-9

Figure 7: Histogram showing the distribution of GP' positive responses to patients' cues and concerns

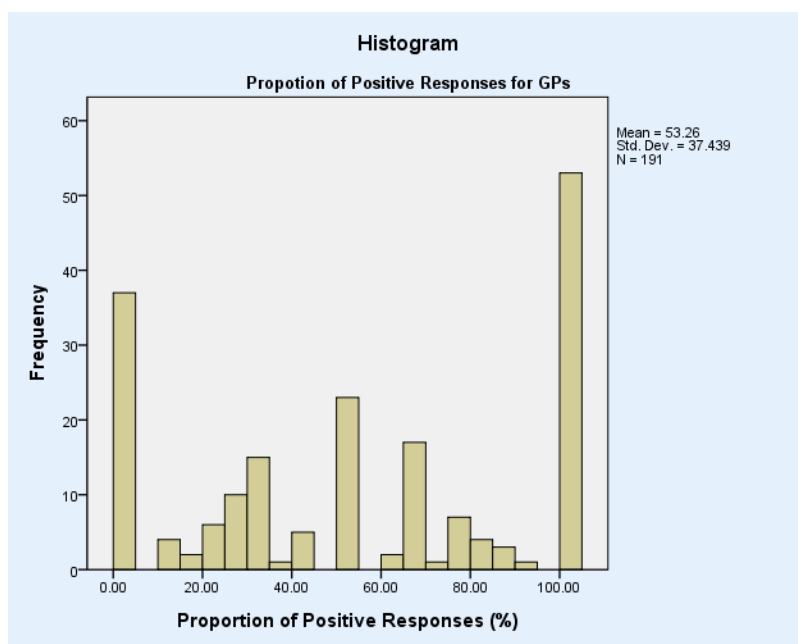


Figure 8: Histogram showing the distribution of Nurse Prescribers' positive responses to patients' cues and concerns

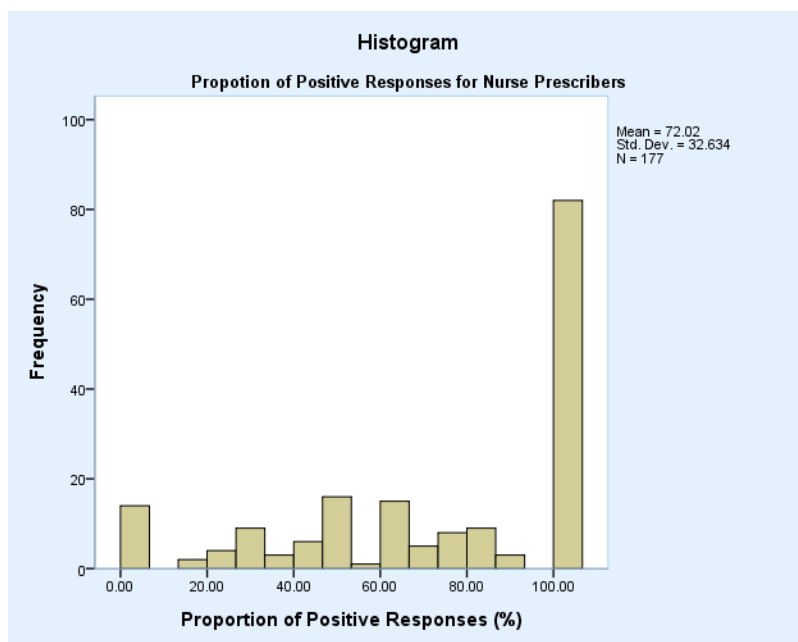


Figure 9: Histogram showing the distribution of Pharmacist Prescribers' positive responses to patients' cues and concerns

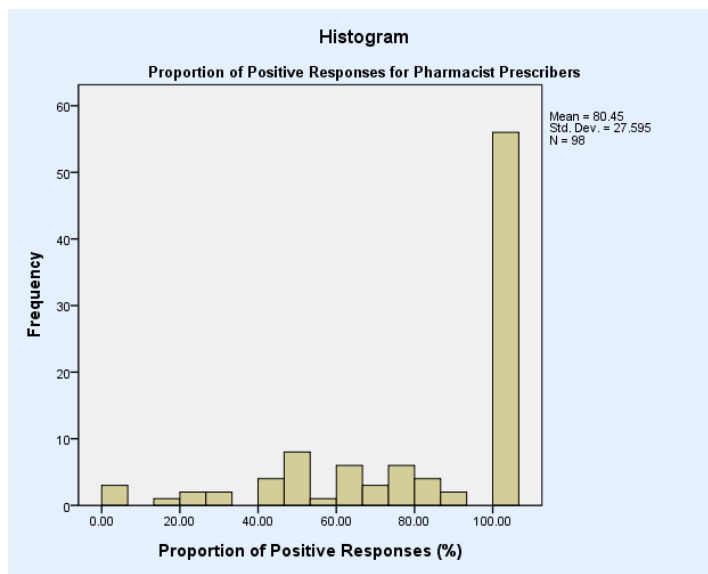


Table 7: Descriptive statistics to assess normality of the proportion of positive responses

<i>Professional Group</i>	<i>Mean</i>	<i>SD</i>	<i>Skewness</i>	<i>Kurtosis</i>	<i>Kolmogorov-Smirnov (sig)</i>
GPs	53%	37.4	-0.77	-1.41	0.000
Nurses	72%	32.6	-0.87	-0.42	0.000
Pharmacists	82%	27.6	-1.31	0.83	0.000

Further evidence of the lack of normality within the proportion of positive responses is also indicated by the standard deviation values. The standard deviation value indicates the degree of 'dispersion' from the mean and a calculation of how many cases are clustered around the mean. A high standard deviation compared to the mean suggests that data is spread out over a wide range of values. With the mean value given in brackets, the standard deviation (SD) values within this data set are high which suggest a wide variation in the distribution of responses. For GPs the SD= 37.4 (53); for nurses the SD=32.6 (72) and 27.6 (82) for pharmacists.

The Skewness value depicts the degree of symmetry within the data which, if plotted, would depict a bell shaped curve if normally distributed. According to Pallant (2010), normally distributed data produces a skewness value of zero with positive skewness indicated by a positive skew value where there is a clustering of positive responses at the low values (on the left hand side of the graph). In the reverse scenario, negative skewness is indicated by a negative skewness value where there is a clustering of positive responses at the high end (on the right hand side of the graph). The negative skewness values for this data seen in Table 7 therefore suggest a clustering of scores at the higher end. Values below 0 indicate that there are too many cases in the extreme which suggests that there are more extreme cases within the data set for nurses and pharmacists.

The Kurtosis score provides an indication of the 'peakedness' of data with positive scores indicating a peaked distribution with negative scores indicating a flat distribution. The nurse and pharmacist Kurtosis values suggest a flatter distribution while the GP values characterises data which is more peaked.

The final evidence indicating the variability within the distribution of positive responses is found in the Kolmogorov-Smirnov statistic which assesses the normality of distribution. A non-significant value suggests that the data is normally distributed. The significance values for this data set were  $p=0.000$  (see table x) suggesting that the data is not normally distributed across the professional groups and therefore violating the assumption of normality, according to Pallant (2010).

In conclusion, the weight of evidence suggests that the distribution of positive and missed responses are not normally distributed and which therefore informed the decision to employ non-parametric tests on this data.

#### **4.4 Prescribers' Responses**

This section presents the proportion of positive and missed responses across the prescriber groups and shows the results of statistical comparisons of positive and missed responses across the groups. The types of positive and missed responses



are then described using descriptive statistics and depicted in a histogram format in Figure 10.

#### 4.4.1 Type of Prescriber Responses

#### 4.4.2 Positive Responses

Table 1 shows the proportion of positive and missed responses across the three groups. Of the total responses, 81% (299/371) of pharmacists' responses were coded as positive compared with 72% (517/719) of nurse prescriber responses and 52% (398/760) of GP responses and these differences were significant ( $\chi^2= 43.9$   $p<0.0005$ ,  $df=2$ ).

Table 8: Proportion of total positive and missed responses by professional group

<i>Professional Group</i>	<i>Proportion of Positive M% (N)</i>	<i>Confidence Intervals</i>		<i>Proportion of Missed Responses M% (N)</i>	<i>Confidence Intervals</i>	
		Lower	Higher		Lower	Higher
GPs	52 % (398/760)	47.9	58.6	48 % (362/760)	41.3	52.0
NPs	72 % (517/719)	67.1	76.8	27 % (202/719)	22.1	31.5
PhPs	81 % (299/371)	74.9	85.9	19 % (72/371)	14.0	25.0

#### 4.4.3 Type of Positive Response

Of the prescribers' positive responses (see Figure 10), acknowledgement was the most frequent type; 44% (165/371) of pharmacist responses were coded as

acknowledgement while this figure was slightly lower in those responses of nurse prescribers (38% - 271/719) and GPs (27% - 207/760).

### **Example of 'Acknowledgement'**

#### Example 1

NP Pt 685: 'This is just like really, really insane...itching, and you can see how inflamed my eyes are.'

NP Response: 'Yes, I can, I can honestly.'

#### Example 2

PhP Pt 595: I can't walk as far as I'd like to walk. Since the fall, I can't even kneel on them

PhP Response: No...yep, yes I know, it's difficult

#### Example 3

GP Pt 313: and then I had tonsillitis and a temperature of one hundred and two, I just feel my body's knackered

GP: I bet that's how you feel

The second most common type of response was 'pursuit' of patients' emotional cues which occurred in approximately one fifth of prescribers' positive responses.

### **Example of 'Pursuit'**

#### Example 1

*Pt554: I'm feeling really lousy. I was nearly asleep out there in the waiting room*

*NP: Oh, and how long has this been going on for?*

#### Example 2

NP Pt 474: It just makes you miserable all the time... I suppose it's affecting my life in many ways

NP response: Yes, of course it does. Well, in that case, it doesn't matter how many times you have to come back. The important thing is that we need to try to get it balanced for you

### Example 3

PhP pt 963: It is agony at the time [arthritis in hands which the patient thinks is being exacerbated by the side effects of Simvastatin]

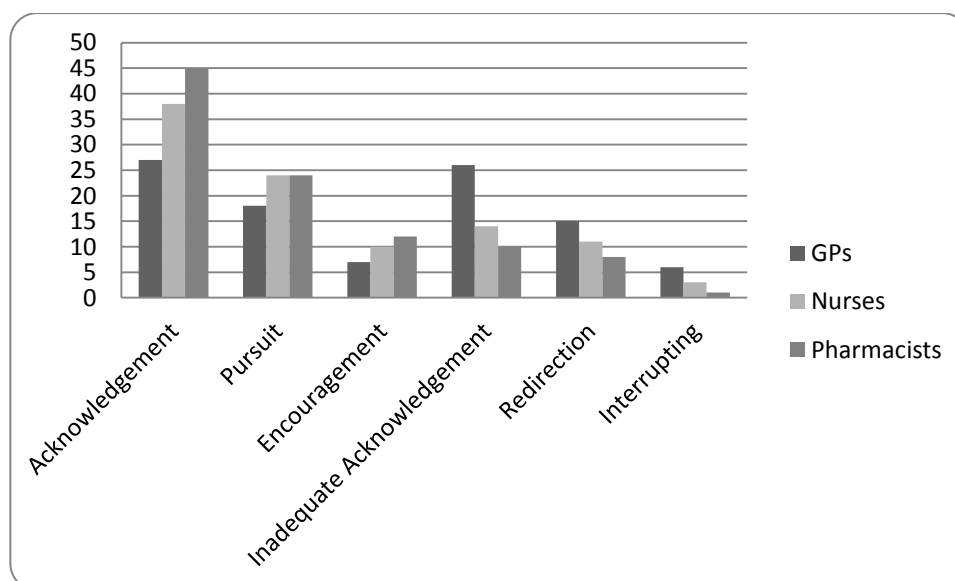
PhP Response: Yes, I can see that, and if it still doesn't do that then we might have to change the Simvastatin to something else

### Example 4

GP Pt 650: uhm (.) but I have been under: a hell of a lot of stress lately so I don't know whether it's due to that

GP: what's happening?

Figure 10. Type of Positive and Missed Response as a Percentage of the Total Response Type, by Prescribing Group.



#### **4.4.4 Missed Responses**

Pharmacists missed 19% (72/371) of patients' cues, which was significantly less than the 28% (202/719) of missed responses in nurses and 48% (362/760) in GPs ( $\chi^2 = 45.01$   $p < 0.0005$ ,  $df = 2$ ). Further analysis using a Mann Whitney U test to ascertain the direction of results indicated that there were significant differences between the proportion of GPs' missed responses when compared to the responses of pharmacists and nurses ( $p < 0.001$ ,  $Z = -5.970$ ,  $U = 5462.5$ ). However, a comparison of nurse and pharmacist missed responses suggests that there are no significant differences between these two groups ( $p = 0.06$ ,  $Z = -1.841$ ,  $U = 7590.5$ ).

#### **4.4.5 Type of Missed Response**

The most frequent type of missed response (Figure 2) across the prescriber groups was coded as 'inadequate' acknowledgment which was higher in GP responses compared with nurse and pharmacist responses. GPs inadequately acknowledged 26% (196/760) of patients' cues and concerns, compared with 14% (98/719) of nurse and 10% (36/371) of pharmacist responses.

#### **Example of 'Inadequate acknowledgement'**

##### *Example 1*

NP Pt 92: It's just that 'cause my bones are all to pot now that's what I'm really suffering with, my back, this joints now gone in my thumb now.

NP response: Yeah, other than that, you're keeping really well? (NP 7)

## Example 2

PhP 920: 'I used to smoke at 16 years. I packed it in when I watched my friend and partner-in-law die of it so I packed it in there and then

PhP response: no response

## Example 3

GP Pt 63: it [her foot] kicked off terrible last night

(-)

GP response: I still haven't got an amount for how much you drink I'm sorry

'Redirection' was the second most frequent type of missed response which occurred in 15% (117/760) of GP responses, 11% (80/719) of nurse and 9% (32/371) of pharmacist prescriber responses. A response was categorised as a redirection if it was felt that the response was a biomedical redirection which attended to clinical aspects of the patient's utterance without acknowledging or pursuing the underlying emotional content.

### **Examples of 'Redirection'**

#### Example 1

GP Pt 114: 'The pain shoots right down my finger'

GP Response: 'Can you make a fist for me?'

#### Example 2

NP Pt 439: 'It's a very sharp stabbing pain [in the belly]'

NP Response: 'Okay, do you drink much alcohol?'

#### Example 3

PhP Pt 962: so now I know I cannot take anything (patient talking about medication for headaches)

PhP: okay

Pt: ever again like that

PhP: uhm: I mean: (-) okay I mean- the the thing is y- you are a still a smoker  
yeah

6% (49/760) of GP responses were coded as 'interruptions' which occurred more frequently compared with 3% (24/719) in nurse responses and 1% (4/371) in pharmacist responses.

#### **4.4.6 Responses by Prescriber Gender**

The analysis also examined the impact of prescriber gender on the proportion of positive responses to patient cues and concerns. Since nurse prescribers were all female and male pharmacists totalled four, a meaningful comparison could only be made in respect of gender of GPs since 12 GPs were male and 8 were female.

A Mann-Whitney U Test revealed significant differences between the proportion of positive responses given by female GPs (53%) compared with male GPs (47%) ( $U=3132.5$ ,  $z=-2.915$ ,  $p=0.004$ ).

#### **4.4.7 Responses by Prescriber Age**

Using Spearman's rho for non-parametric data, there was no correlation between age of prescriber and the proportion of missed responses:  $r=0.-062$   $n=475$ ,  $p<0.18$  nor positive responses:  $r=0.-071$   $n=474$ ,  $p<0.12$

#### **4.4.8 Responses by Consultation Length**

The total number of cues and concerns expressed increased with consultation length (Spearman's  $r=0.31$ ,  $n=528$ ,  $p<0.0001$ ). However, there was no relation between the proportion of missed opportunities and consultation length (Spearman's  $r=-0.07$ ,  $n=528$ ,  $p=0.109$ ).

## **4.5 Conclusion**

The discussion and conclusions drawn from these research findings are found in the corresponding published paper (Riley et al., 2013) found in Appendix R. The discussion points outlined in the paper are reviewed below.

Patients communicated on average 3.4 cues and concerns per consultation and it was highlighted that this frequency is higher compared with previous studies (Levinson et al., 2000). Of those concerns expressed, the predominant cue/concern type related to biomedical concerns. Other cues and concerns related to concerns about medication, and psychosocial issues related to diagnosed mental health conditions such as depression or anxiety and stress relate to work and other life events such as bereavement. This corresponds with previous findings (Zimmermann et al., 2007).

The proportion of medication and lifestyle cues and concerns were higher in pharmacist prescriber consultations which is likely to be explained by the higher frequency of medication review consultations undertaken by pharmacists. In these consultations pharmacists and patients are more likely to discuss medication and lifestyle risk factors associated with the chronic disease being managed, such as hypertension or diabetes.

Pharmacists and nurses were more likely to respond positively to patients' cue and concerns compared to GPs. Possible explanations for this may relate to the incorporation of communication skills training in independent prescriber training. Other reasons could relate to the potential caveat in relation to self-selection bias in that pharmacists who choose to undertake prescriber training may be more likely to have an interest in working directly with patients and/or may have more adept communication skills.

The paper concluded that while there are limitations associated with the study findings, it would appear that pharmacist and nurse prescribers appear to be responding within a patient centred framework. While the reasons for this are unclear and perhaps complex, the mandatory inclusion of communication skills training for 'new prescribers' can only serve to benefit both professionals and patients.

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## 5.0 Findings and Discussion

The chapter will present and discuss the key findings from the qualitative analysis which undertook a closer examination of a subsample of 30 transcripts of audio recorded consultations. The aims of the qualitative analysis were to:

1. Understand the ways in which GPs, nurse and pharmacist prescribers employ emotional labour within the context of a healthcare encounter
2. Identify the facilitators and barriers to the employment of positive emotional labour within healthcare encounters between patients, GPs, nurses and pharmacists
3. To understand how the sociological context (institution, gender, professional training) influences the management of patients' emotional cues and concerns

The qualitative analysis focused on identifying and explicating emotional labour employed within the context of a healthcare encounter between patients and GPs, nurses and pharmacist prescribers. The analytical approach has employed the term emotional labour in favour of the term emotion work since it recognises that the emotion work undertaken by healthcare professionals is taking place within an organisational setting or work context. The focus of the analysis was interested in identifying the range of positive emotional labour employed within a healthcare encounter and specifically the range of caring work and personal and relational skills employed within a patient centred framework (Smith, 2012; Stewart et al., 2003). The analysis also identified the facilitators and barriers, challenges or constraints to offering positive emotional labour within healthcare encounters between patients, GPs, nurses and pharmacists.

Emotional labour theory is explicit in its endeavour to make emotional labour visible. In making it visible, it is argued, the range of positive emotional labour employed in healthcare encounters, enables it to be valued and not taken-for-granted (Smith, 2012). Likewise, one of the objectives of this analysis was to identify the emotional labour undertaken by nurse, pharmacists and doctors within the setting of general practice in order to make it visible and valued in the

way that previous authors have also undertaken to do in other institutional settings such as hospitals (e.g. Williams, 2012; Gray and Smith, 2009).

In contrast with the first phase of the study, this analysis viewed positive emotional labour within the overall context of the consultation and did not specifically focus on cue-response sequences alone. This method provided a greater understanding of emotional labour processes such as empathy and evidence of listening which can benefit from viewing the consultation in its entirety rather focusing on specific sequences.

Finally, the analysis was also interested in recognising the ways in which organisational or institutional settings can also play their part in the ways feelings are expressed and managed. For this study, the focus was centred on emotional labour in healthcare encounters between patients and GPs, nurse and pharmacists, within the setting of general practice. Therefore, the analysis was mindful of this particular institutional setting and understanding how the demands and expectations of general practice could play a part in influencing the way emotional labour is employed within specific settings and contexts by different professional groups. In addition, the analysis recognises the role that the professional status, identity and training of different professional groups, might affect the employment of emotional labour within the encounter.

Although, parts 1-3 focus more on the professional and their use of emotional labour, it is important to acknowledge the dynamic and relational influences of emotional labour. This acknowledges that the ways in which emotions are expressed and managed do not occur in an interactional vacuum but rather within the context of a more dynamic relationship in terms of what and how emotions are communicated and managed by both patient and professional.

Each section presents consultations from different professionals and is intended to illustrate the themes presented under each section. Within the findings, I will briefly present data from my field note diary which capture observations and feelings about particular consultations, observed whilst listening to and analysing the consultations. In particular, the notes reflect on what stood out in the consultation and some of the key reasons for including consultations under the specific themes and why in some cases, a consultation or a part of the encounter seemed to stand apart from other consultations.

The findings of the qualitative analysis are presented in 2 parts:

Part 1: Facilitators of Positive Emotional Labour

Part 2: Challenges and Constraints to Employing Positive Emotional labour

- (i) Emotional Disengagement – Keeping it Clinical
- (ii) Task Focused Consultations
- (iii) Agenda Driven Consultations

## 5.1 Facilitators to Positive Emotional labour in Patient Centred Healthcare Encounters

The analysis identified the following range of facilitators or approaches employed in positive emotion labour:

Table 9: Facilitators to Positive Emotional Labour

<b>FACILITATORS of POSITIVE EMOTIONAL LABOUR</b>	Empathic Communication – communicating understanding through minimum or extended responses
	Legitimising patient's reasons for visiting - taking patients seriously
	Validating patient's cues and concerns through reiteration, reflecting back, acknowledgement
	Exploring patients' c/c - Inviting patients to talk
	Narrative co-construction – encouragement or involvement in (re)telling of patients' story
	Evidence of listening, attentiveness and attuning to patient's world
	Voice of medicine for reassurance and confirmation
	Providing space in the consultation evidenced by patients' completion of concerns and unrushed consultations
	Investing in the relationship/relational depth – rapport building
	Improvisation – e.g. flexi script/voice switching i.e. voice of medicine to voice of lifeworld, using humour, side conversations

Within this section, the range of facilitators identified in positive emotional labour involved in delivering patient centred healthcare encounters will be presented and discussed using cases to illustrate how these facilitators or approaches/skills are employed within different healthcare scenarios. It is important to note that these facilitators are often inextricably linked to each other and may be co-dependent. For example listening attentively can provide space in the consultation for patients to talk while listening attentively and tuning in to the patient is part and parcel of empathic listening and patient centredness and enabling. Communicating understanding (empathy) is dependent on the processes involved in empathy, such as listening and attuning to the patient's world and is not just evident in the response alone.

While phase one of the study presents the types of responses (positive and missed) to patients' emotional cues and concerns, the qualitative analysis in phase 2 presents the spectrum of emotional labour which has been identified in a sub-sample of 30 healthcare encounters. In contrast to phase one, this section will present the depth and breadth of emotional labour, as evidenced in extended responses, attentiveness and the depth of engagement by the healthcare professional. In phase one, positive responses such as acknowledgement, do not necessarily differentiate a minimal acknowledgement from a more in-depth or extended acknowledgement or empathic response which may involve a greater degree of emotional labour. This section will therefore present and discuss these aspects of positive emotional labour which are employed by GPs, nurses and pharmacists and which reflect a patient centred approach to providing health care.

One way in which professionals engage in what some authors describe as positive aspects of emotional labour (e.g. Smith, 2012; Bolton, 2006) is in their empathic communication and approaches to managing or responding to patients' feelings (such as worries, concerns or fears) about their condition, illness, current symptoms or treatment. This relates to the aspect of healthcare which involves caring and being cared for within a patient centred approach. For example, evidence of professionals' empathic process is found in the way that

GPs, nurses and pharmacists acknowledge or validate patients' feelings by reflecting back the particular cue/concern to the patient or by communicating to the patient that they have understood and recognise why they might feel as they do. By responding in this way, it indicates to the listener that the healthcare professional has been actively listening or attentive to their patient, that they are engaged with the patient's narrative or lifeworld and that their expressed emotional cues and concerns have been heard and understood. Communicating one's understanding in response to patients' expressions of feelings or emotions, represents a key aspect of empathic process as defined by Rogers who defined empathy as '*sensing the feelings and personal meanings which the client is experiencing in each moment, ... and when he can successfully communicate something of that understanding to his client*' (Rogers, 1951: 61).

Positive aspects of emotional labour are also evident in the way professionals provide space in the consultation to enable patients to tell their story and to communicate their biopsychosocial needs, cues and concerns. Providing space which enables patients to talk is evident when, for example, patients are explicitly invited to talk or elaborate upon their concerns, are able to complete their concerns, and are not interrupted. For patients, healthcare professionals can provide signals which indicate their interest in and openness to hearing the patient's story. These signals, identified in previous research, subsequently enable the patient to participate and communicate their needs, ideas and concerns (Jones and Collins, 2007; Collins et al., 2003). These signals may be conscious or unconscious but either way they play an important role in providing space in the consultation and opportunity to talk. Signalling and providing space will be explored within the cases below.

Importantly, there are instances in which healthcare professionals appear invested in the consultation and communicate empathetically through extra or extensive positive emotional labour. In these instances, it could be seen that healthcare professionals are engaged or invested in the patient in a way that extends beyond what is communicated or offered in other consultations. The spectrum of positive emotional labour was found across the professional groups. The cases given below are intended to be illustrative of the range of positive emotional labour identified in the sample of 30 recordings. Presenting three cases allows the reader to view the ways in which emotional labour is employed

as part of a process and to view the consultation within its entirety enables a greater understanding of the complexities and interdependence of the range of facilitators of emotional labour. The cases include the following:

**Case A:** GP and patient 313 – the first consultation (patient 313) captures a healthcare encounter between a GP and a patient who has returned with on-going symptoms related to an acute illness.

**Case B:** Nurse Prescriber and Patient 474 - the second consultation captures an encounter between a nurse and her patient who attends as part of a routine asthma review.

**Case C:** Pharmacist Prescriber and Patient 593 - the third consultation captures an encounter between a pharmacist and her patient who has come in to discuss the results of his blood sugar within a routine diabetes clinic

### **Case A: GP and Patient 313**

Consultation 313 between a male GP and a female patient,

The GP states in his opening statement in line 1: *'So you're no better, tell me more about it, what's troubling you most of all'*. In this opening, the GP acknowledges that the patient is still unwell. It is unclear how the doctor knows that she is still unwell but a possible explanation could be that the patient is returning to see her GP and/or this may have been identified when the patient made the appointment.

In the GP's opening statement, he is explicitly inviting the patient tell her story, by providing space in the consultation for the patient to talk which is evident in the way the patient's story subsequently unfolds. We learn that the patient has experienced a catalogue of what appears to be acute illnesses - she has conjunctivitis and an on-going chest infection which she is unable to shift. She says 'I just feel very unwell'.

The open question format 'what is troubling you most of all' provides the patient with the opportunity to voice her reason(s) for visiting and to say more about what is troubling her. The open question is also a recognised device and reflects an open enquiry and opportunity for patients to express their reasons for visiting

the health professional (Marvel, 1999). Furthermore, there is evidence to suggest that employing an open invitation of this nature in the opening of the consultation is good practice since it invites patients to disclose their reason(s) for visiting. In doing so, uninterrupted, patients are able to communicate important clinical and psychosocial information to the professional from the outset of the consultation (Marvel, 1999). Evidence suggests that when patients are interrupted and unable to voice their reason(s) for visiting, it can reduce professionals' misunderstanding of patients' biopsychosocial needs (Dyce & Swiderski, 2005). Furthermore, by inviting patients to tell their story in the voice of the lifeworld, and what may belie their visit to the healthcare professional, the gaze is focused on patients' understanding of their biopsychosocial world and not just medicalised symptoms (Stewart et al., 2003; Marvel, 1999).

### **GP patient 313**

*From opening*

#### Extract 1

- 1     *GP: So you're no better (.) tell me more about it, what's troubling you*
- 2     *most of all?*
- 3     *Pt: >>it's just not going away (.) it's round here now, I've got*
- 4     *conjunctivitis, it's burning down there, my chest is starting burning and*
- 5     *I'm wheezing a*
- 6     *little, you*
- 7     *know like when you can feel it yourself*
- 8     *GP: mm*
- 9     *Pt: I just feel very unwell*
- 10    *GP:                               [mm and how long as this being going on for*
- 11    *now?*
- 12    *Pt: since last Saturday*
- 13    *GP: that's it (.) yeah*
- 14    *Pt:                               [and the week before that I had a water infection*
- 15    *GP: I know*



The GP's emotional labour is evident in the way he empathises with her situation and validates how she feels within the context of her feeling unwell for so long. The empathy and validation of her feelings is evidenced repeatedly during the consultation, for example, when he confirms his understanding of her illness journey when he says 'I know' (Extract 1, line 10); when he responds by saying '*I bet that's how you feel*' (Extract 2, line 8) and again when the GP summarises the patient's illness experience at the end of the consultation when he confirms '*you're definitely going through a very bad patch at the moment*' (Extract 4, line 28). The confirmatory responses expressed by the GP indicate that the GP has been listening to the patient, that he is validating how the patient feels and importantly that he has conveyed his understanding of the patients' experience of feeling unwell. Furthermore, the responses indicate that the patient is re-visiting her GP and that her previous reasons for visiting are known to the doctor and they are also known to each other. This is supported by previous evidence which found that where patients and healthcare professionals are more familiar with each other, the professional is more likely to raise prior information about the patients' biopsychosocial context (Jabaaji, 2008).

#### Extract 2

- 1 Pt: *and the week before that I had diarrhoea and sickness (.)*
- 2 *couple of*
- 3 *weeks before that I had the blood in my urine*
- 4 GP: *yeah*
- 5 Pt: *>>and then I had tonsillitis and a temperature of one hundred and*
- 6 *two (.) I just feel my body's knackered*
- 7 GP: *I bet that's how you feel*
- 8 Pt: *mmm*
- 9 GP: *mmm*

Further evidence of positive emotional labour can also be evidenced in the way the GP provides space and facilitates the patients' story-telling in the consultation. This is evidenced by the lack of interruptions and also in the way that he encourages her to tell her story through supportive conversational continuers such as *mmm*, *uh huh*, *I know*. The GP also appears to be actively

collaborating with the patient in the telling of her story by acknowledging, validating and exploring her concerns, for example in Extract 1, line 6, the patient says '*I just feel very unwell*' which the GP acknowledges with a sympathetic '*mmm*'. Subsequently, the GP enquires about the duration of her illness to which the patient responds by saying: '*since last Saturday*'. The doctor's responses '*that's it, yeah*' (line 9) and later '*I know*' (line 11) in response to the patient's other health problems – the '*water infection*', for instance, acknowledges the duration of her illness while perhaps serving as a narrative device to encourage the patient to continue without redirecting her down a biomedical route where her telling of the story could become medicalised whereby a health care professional may direct questions about symptoms in order to formulate a medical diagnosis based on biomedical symptoms (Conrad and Schneider, 1992). The doctor's response and question guide the narrative and perhaps reflect the way in which the GP is able to improvise in switching scripts between the voice of medicine and voice of the lifeworld. This is evident in his voice of medicine question '*and how long has this being going on for now?*' (Extract 1, line 7) while the GP's more elaborative enquiries later in the consultation, for example when he enquires '*what's stopping you from sleeping?*' '*so what happens when you go to bed*' (line 37) serves as a device to explore patients' cues and concerns and which encourage or explore rather than detract the patient from telling her story in her own words.

The importance of storytelling within patient centred or narrative-based medicine has been well-documented in the context of healthcare encounters (Stewart et al., 2003; Greenhalgh, 1999; Elwyn & Gwyn, 1999). The healthcare professional's role in storytelling is important and is evident in the provision of space in the consultation through open enquiry and by listening and communicating understanding. As Heath poignantly highlighted '*stories can only be told when people have time to talk and listen and to hear*' (Heath, 1998: 90)

In these examples and in the example in Extract 2, they convey that the GP has been listening and has been '*sensing*' the patient's illness journey. In extract 2, the GP's explicit acknowledgement '*I bet that's how you feel*' in response to the patient voicing her recent history of health problems convey that the GP is validating and normalising how her illness experience may be impacting on her emotionally. The patient says '*and then I had tonsillitis and a temperature of*

*one hundred.. [and] ... a couple of weeks before that I had the blood in my urine'* and so the GP's response conveys understanding and empathy, and indicate that the GP has been listening attentively to the patient. When in validating the patient's feelings in response to her myriad of health problems, the GP normalises how she feels; he communicates that it is normal to feel sad or 'low' when feeling unwell. When the GP acknowledges these experiences, the patient agrees with an *mmm*. This agreement with what has been said suggests that the patient and doctor are engaged and have developed an agreement or alliance in their understanding. This agreement in understanding in the relationship is often referred to as the therapeutic alliance and is a key dimension of patient centred care. Mead and Bower defined the therapeutic alliance as 'fostering a caring, sensitive and sympathetic manner in consultations' and it appears that this GP is working hard to foster and develop this relationship in this encounter (Stewart, 2003; Mead and Bower, 2000). In this consultation, it would also appear that the GP is invested in this patient consultation, that he is employing emotional labour to foster a relationship and sense of connectedness to his patient by attuning to her world. The importance of connectedness was identified by Epstein & Street (2011) as being an important component of shared-mind. Epstein & Street defined connectedness as being on the same wavelength which is enabled when professionals demonstrate mutual understanding, empathy and compassion within the consultation process and is evidenced by the extent to which patients participate and how doctors respond.

Validating patient's cues and concerns offers reassurance to someone as it communicates the message "it's okay to feel like you do...it's normal". Secondly, it is a way of making someone feel heard and understood while fostering a trusting relationship with their healthcare professional. It is argued that when a patient trusts the professional, they are more likely to open up to them (Epstein et al., 2007; Bylund and Makoul, 2005; Corbert-Owen et al., 2001). Having one's feelings validated is an important aspect of empathic communication which is desired by patients and is beneficial to them. For example, in a study exploring women's experiences of miscarriage, women reported that it is important to have their feelings and concerns validated as it makes them feel understood and listened to (Corbert-Owen et al., 2001).

Further evidence of emotional labour is found in the extract 3 in which the GP again validates the patient's emotional cues and concerns and normalises how she feels. This is evident in his response to the patient who says '*...but I can't, that's my trouble, I can't, I can't sleep...I know it sounds daft*'. The patient's addition of '*I know it sounds daft*' is noteworthy. One can only surmise about the reasons underlying her expression '*I know it sounds daft*' or later when she says '*my body's rotten*' but what is important is the way the GP picks up on this cue, and in doing so, demonstrates his attentiveness to the patient's cues and concerns when he says '*it doesn't sound daft, it's something I hear from people every day pretty much every day. What's stopping you from sleeping*' (lines 8-9). He validates and explores her concerns when he enquires about what is stopping her from sleeping which subsequently opens up a discussion about her sleeping problems and the possible reasons for her sleeplessness, as attributed by the patient.

### Extract 3

- 1 Pt: I've tried not to give in (.) I've given up the medication (.)you know
- 2 I told you=
- 3 GP: =yeh
- 4 Pt: I'm trying to lose weight (.) and hhh (.) I know I need to sleep
- 5 but I can't (.) that's my trouble (.)I can't (.) I can't sleep=
- 6 GP: =uh huh
- 7 Pt: I know it sounds daft=
- 8 GP: =it doesn't sound daft, it's something I hear from people (.) every
- 9 day (.) pretty much every day (.) what's stopping you from sleeping?
- 10 Pt: (.) I dunno
- 11 GP: (.) so give me an example of a typical night?

In extract 4, proceeding the discussion about sleeping, the patient then describes additional symptoms 'sweaty palms ... a high temperature' which she describes as 'weird' (lines 2-3). The doctor acknowledges these concerns by saying '*not good is it really?*' (line 5) and then switches to the voice of medicine when he offers to give her a physical examination which the patient agrees to. In employing the voice of medicine and examining her, the GP is also

acknowledging that the patient is physically unwell by later confirming her account in the voice of medicine, for example 'the lymph glands are tender...sinusitis'. Evidence suggests that patients are looking for reassurance that they are 'bona fide' patients; that they have genuine reasons for visiting and are not wasting the doctor's time (Eaton & Webb, 1979). Additionally, the doctor's recognition that the patient is still unwell may allay any 'entitlement anxiety' (Fisher and Ereaut, 2012). This refers to the anxiety experienced by patients when they question whether they are deserving of the doctor's time and are therefore looking for reassurance or confirmation that they had genuine reasons for visiting (Fisher and Ereaut, 2012).

Perhaps, in offering to physically examine the patient, and in acknowledging the patient's symptoms in the voice of medicine, it signals that the patient's concerns and reasons for visiting have been taken seriously. In this example, employing the voice of medicine offers reassurance and perhaps reaffirms the patient's description of her symptoms. Employing the voice of medicine in this way differs from instances in which it is employed to re-direct the consultation down the medical route without addressing or integrating the patient's cues and concerns. This reflects the importance of remaining responsive to patient's biopsychosocial needs requiring a flexibility and ability to improvise in the moment in order to accommodate or tune in to patients' concerns.

In Extract 4, towards the end of the consultation, the patient appears to summarise how she feels currently at the moment when she says '*I think I'm just a bit rotten at the moment (laughs) (line 1-2)*'. The GP acknowledges and validates her concern in line 3 by saying '*you are*' and then proceeds to provide the patient with various options about a course of action when he says '*and the question is, what to do about it*' (line 3). The GP's response also suggests that he has taken the patient seriously which has also been highlighted by patients as an important consultation skill (Bensing et al., 2013).

This extended acknowledgement of the patient's illness experience is notable when compared with consultations in which it is not offered (see section 2). The GP appears to go to great lengths to explain the patient's symptoms and voice and explain the possible courses of treatment whilst responding empathetically to the patient's illness experience. In this and other examples, the GP appears to employ extensive emotional labour, evident in his attentiveness and effort to

communicate his understanding of the patient and to also voice his decision making process to the patient.

The GP voices his rationale for the suggested options for treatment and appears to work hard to communicate and elaborate on his understanding of the patient's condition whilst acknowledging and accommodating the patient's experiential illness journey. For example, the GP explains that the sweatiness in her hands could be symptomatic of her illness or a sign of anxiety and worry which he normalises within the context of her feeling unwell – *'sweatiness in the hands is a sign of anxiety and worry and I can understand, that, you know, a lot of that is going through your mind at the moment 'cause you know that you're not quite right and that could be a few causes to the sweatiness of the palms'* (lines 7-11).

The doctor proceeds to explain about whether the cause could be a virus as perhaps a way of setting the scene for his course of action. The doctor voices these deliberations and decision making with regards to treatment, to the patient, and goes to great length to do so. In this way, the doctor's rationale, is similar to Peräkylä's (1998) type II format for delivering a diagnosis in which doctors voiced their rationale during a physical examination, using signs and symptoms to support their rationale. This is often used to pre-empt disagreement or misalignment with the patient's own evaluation of their symptoms or expectations for a specific treatment. Peräkylä argues that the second format is shown to provide an opportunity for the patient to participate in the consultation by offering their response to the doctor's decision which enables the patient to provide more information about their symptoms and particular concerns.

However, and importantly, what the GP does not lose sight of is the patient's illness experience which appears to remain a focal point in the decision making process. In this extract, the GP communicates to the patient that, despite his reluctance to prescribe more antibiotics, he nevertheless recognises that she is still unwell when he says *'my feeling is that uhm, aghhh, that I'm loathe to prescribe any more antibiotics to you 'cause you've had loads over the past month or so haven't you but I can see that you are still unwell you're still painful round the throat and probably have got sinusitis. I'm gonna have to go for something that's gonna fix it.'* (Extract 4, lines 13-17)

#### Extract 4

- 1 Pt: and uhm this morning my eyes were very sticky (.) I think I'm just  
2 a bit rotten at the moment (laughs)=
- 3 GP: =you are and the question is, what to do about it (.) so the  
4 penicillin hasn't done the trick (.) and what that means is that the thing  
5 causing this is a virus and no antibiotics will help (.) and time will just  
6 have to do its stuff or it's a bacteria that's resistant to penicillin and just  
7 wasn't the right one (.) uhm the sweatiness you're getting in your  
8 hands could be a sign that you're occasionally getting a fever or  
9 sometimes to be fair(.) sweatiness in the hands is a sign of anxiety and  
10 worry and I can understand, that (.) you know, a lot of that is going  
11 through your mind at the moment 'cause you know that you're not  
12 quite right and why that so that could be a few causes to the  
13 sweatiness of the palms (.) my feeling is that uhm, aghhh, that I'm  
14 loathe to prescribe any more antibiotics to you 'cause you've had loads  
15 over the past month or so haven't you but I can see that you are still  
16 unwell you're still painful round the throat and probably have got  
17 sinusitis. I'm gonna have to go for something that's gonna fix it. What  
18 I would say is that I'll give you a prescription for erythromycin and  
19 hang on to it for a couple of days and if you could just take the  
20 prescription away with you and if you're feeling you're turning a corner  
21 (.) don't cash it in (.) but if you're feeling no better by Sunday then  
22 cash it in and commit yourself to a week's supply
- 23 Pt: I don't think I can take that one=
- 24 GP: =you can't, I think you've mentioned that to me before (.) I'll give  
25 you something else then, I don't want to make you feel even worse=
- 26 Pt: =okay (.) I'm just trying to look after m'self (.) and it just don't  
27 seem to be working=
- 28 GP: =no, you're definitely going through a very bad patch at the  
29 moment

The GP proceeds to write a prescription with the provision that she should '*hang on to the prescription for a couple of days*' (line 19) and that if she begins to feel better or 'turn a corner' as he phrases it, then the patient should not 'cash it in'. He also provides her with an alternative option in which he suggests that she can take the course of antibiotics if she continues to feel unwell after a given time period. The GP has provided the patient with options for treatment which are mindful of the patient's expressed concerns about not getting better while also taking into consideration the usefulness of antibiotics if the cause of her symptoms are viral not bacterial. It appears the GP has worked hard to reach a point in the consultation where he is able to make recommendations based on the experiences, concerns, preferences of the patient. Perhaps this preparatory work has centred on the emotional labour involved in promoting relational depth in the consultation process. The relational depth is the fruit of his emotional labour - in listening and empathising, in creating and providing the space for the patient to talk, for him to listen and accurately communicate his understanding to the patient. As previous authors have highlighted, to elicit patient's beliefs and experiences about their condition or treatment requires good communication skills and an investment in the process (Jordan & Chambers, 2002). These aspects of the consultation process are also reflective of attunement, a communicative feature of shared mind, as outlined by Epstein and Street (2011). Attunement refers to the development of mutual understanding and consensus requiring the patient to be able to participate in the consultation as facilitated by the empathy and compassion offered by the health care professional, as has been demonstrated in this consultation.

Furthermore, in providing options and entrusting the prescription to the patient with suggestions about two courses of action, suggests that the GP is sharing power and responsibility with the patient. In including the patient in this way, in communicating his rationale for his recommendations for treatment and providing options to the patient, the doctor could be seen to be involving the patient in the decision to 'cash in' or not cash in the prescription and commit to a course of antibiotics. This transference of power/trust is regarded as pivotal in the fostering of a trusting therapeutic relationship between professional and patient. Fugelli, for instance, viewed trust as 'a transference of power, to a person or to a system, to act on one's behalf, in one's best interest' (Fugelli, 2001: 575). This GP appears to be acting in the patient's best interests when he



gives the prescription to the patient with the option of her using it or not – the decision has been transferred to the patient. It also possible that in issuing the prescription, the doctor is showing that he cares. Previous research has highlighted that the prescription becomes a symbol of a healthcare professionals' care and concern and their willingness to help (Comaroff, 1976). Furthermore, the act of issuing the prescription serves to maintain a relationship between the patient and healthcare professional (Harris, 1980).

These examples also reflect that emotional labour is employed when, for instance, the GP accommodates the patient's psychosocial concerns. There is also evidence of the GP employing emotional labour to manage a scenario in which competing demands may be placed on the doctor in terms of the patient's expectations or perceived expectations regarding the course of treatment.

There are two additional noteworthy observations about this consultation derived predominantly from listening to the consultation. Firstly, the consultation is free from disturbances such as typing or telephone interruptions. Not being interrupted and being in a consultation with a healthcare professional who is not distracted perhaps signals, to the patient, that the professional is fully present, listening and attentive to their concerns – this is a skill or approach which is desired by patients while also reflecting a more patient centred approach to the health care encounter (Deledda, 2013, Bensing, 2011, Stewart et al., 2003).

Secondly, the consultation does not feel rushed. This is perhaps reflective of the way in which the GP's consultation style is unhurried and reflected in the time and space given to the patient to enable her to talk and tell her story. For patients, feeling unrushed and having time, are additionally important to them (Deledda, 2013, Bensing, 2011) as well as conferring clinical and therapeutic benefits (Stewart et al., 2003). There is also evidence to suggest that adopting a patient centred approach to the consultation does not necessarily take longer (Levinson, 2000; Marvel, 1999). However, in this consultation, the consultation took 12 minutes, 38 seconds and therefore did exceed the allocated 10 minute consultation time.

All of the above observations about the range of emotional labour carried out in this consultation are approaches, skills and ways of responding preferred by patients (for example Deledda et al., 2013; Mazzi et al., 2013; Bensing et al.,

2011). Displays of empathy, active listening, attuning to the patient and conveying support and improvisation in the consultation as shown by the switching of voices from lifeworld to voice of medicine, are evidence of the range of positive emotional labour employed in this consultation. One of the skills required for emotional labour is the ability to 'understand and interpret the needs of others' (James, 1992: 154) and is undoubtedly a skill evidenced in the emotional labour of this GP.

The following entry is taken from my field note diary and reflects on some of the reasons why consultation 313 was striking to listen to.

*From the diary: a personal reflection on consultation 313*

When I first heard this consultation, it really stood out from the majority of consultations. Why? Firstly, the GP offering positive emotional labour was a male GP and while other male GPs also employed various facilitators of emotional labour, few of them offered it consistently, throughout the consultation.

Secondly, after listening repeatedly to this consultation, I wondered that perhaps, in the process of reading the literature on patient centred approaches, and some of the barriers and facilitators to this approach and to being empathic, it informed or influenced my expectations about what a 'good' consultation 'might' sound like. I began to wonder if this value-laden position and assumptions about patient-centeredness being a 'good thing' was realistic. Was I expecting too much from these professionals? Until I listened to this consultation, I had identified examples of patient centred approaches within previous consultations but employed intermittently. I had also heard examples of some of the barriers to patient-centeredness or barriers to responding empathically to patients' cues and concerns.

To some extent, my expectations had also been informed by having been a recipient of an empathic and person-centred therapist. However, unlike counselling and psychotherapy, healthcare professionals need to contend with the art or act of balancing patients' clinical needs whilst incorporating patients' psychosocial needs within a limited time-frame. In many respects, I feel that this is one of the reasons why this consultation stood out. The GP encouraged

the patient to tell her story and he appeared to listen and respond empathically to the patient's health and illness experience. The GP showed that he was listening and engaged with the patient on an emotional and clinical level – he acknowledged and validated the patient's cues and concerns and offered reassurance or empathy in response. The doctor appeared to be adopting a more patient centred approach throughout the consultation. I feel these aspects of emotional labour are fundamental to a patient centred and empathic approach to healthcare. I can only surmise but perhaps the patient did not expect more antibiotics but rather the 'treatment' was in the care and compassion offered to the patient and having the opportunity to talk and be listened to – as Engel highlighted (and many others besides) – 'To know and understand is obviously a dimension of being scientific. To be known and understood is a dimension of caring and being cared for' (Engel, 1988: 124). This is perhaps key as to why this consultation stood out for me.

Consultation 313 is illustrative of other examples of positive emotional labour which were evident across the professional groups. Evidence of empathy (listening, validating, reflecting back patients' concerns), the professional's approach to providing space and opportunities for patients to talk and tell their story; and approaches to understanding, exploring and recognising patient's biopsychosocial experiences of health and illness; ways of sharing power and responsibility within the consultation and approaches to nurturing the therapeutic relationship are evident in this consultation. These are all recognised as patient centred approaches to the provision of healthcare (e.g. Epstein et al., 2005; Mead and Bower, 2000) and therefore highlights the emotional labour involved in delivering empathic and patient centred healthcare.

### **Case B: Nurse Prescriber and Patient 474**

This 20 minute consultation takes place within a morning asthma clinic provided by a nurse prescriber. The consultation centres around a female patient who is experiencing difficulties managing her asthma. One of the striking aspects of the opening sequences is the way the nurse provides space in the consultation which

enables the patient to talk. In not interrupting and reducing her responses to narrative continuers and minimal acknowledgments to the patient's cues and concerns (such as *mm, mmm, yeh, right, okay*), the nurse creates and provides space in the opening of the consultation for the patient to talk at length about her difficulties in managing her asthma, its impact on her emotionally and physically within the context of her day-to-day life. The nurse's opening in line 1 '*how have you been*' invites an open response. Perhaps the phrasing and warmth (an observation derived from listening to the consultation) communicated in the invite subsequently encourages the patient to express how she genuinely feels and is perhaps evidenced by the patient's candid response to the invite when she indicates that she has been feeling '*bad*'. In the space that the nurse creates in the consultation, the patient continues to express how she has been feeling both physically and emotionally. The patient explains she has had a persistent asthma related cough which is impacting on her physically and emotionally as indicated when she iterates that she is '*fed up of, I'm just fed up of coughing it's just gone on: and on for years it's just really constant*' (lines 5-7).

Although the nurse's responses appear to be minimal utterances (*mm, yeh*), later on in the consultation (see extract 2 and 3), it is evident that the nurse has been attending to the patient's emotional cues and concerns around managing and coping with her asthma – the patient expresses her cues and concerns at great length, perhaps as she is given the time and space to do so. In these opening sequences, it appears that the patient has been granted the opportunity to talk while the nurse listens to her story unfold without interrupting or redirecting her down a biomedical route.

### **Nurse Prescriber Patient 474**

#### Extract 1

*From opening*

- 1     NP: *how have you been*
- 2     (-)
- 3     Pt: *.hh (.) bad (.) uh huh [huh huh*

4 NP: [mmm (.) right  
 5 Pt: well I'm just fed up of: (.) I'm just fed up of coughing  
 6 (-)  
 7 Pt: it's just gone on: and on for years it's just really constant and (.)  
 8 NP: °yeh°=  
 9 Pt: =I mean today funnily enough I haven't bin too bad  
 10 NP: °yeh°=  
 11 Pt: but most- (.) usually: (.) uhm (.) I never used to cough much at  
 12 Night just one little cough to clear my throat before I settled down (.)  
 13 but sometimes bedtimes an I'm cough cough cough before .hhh  
 14 ((cough)) I'm clear an everything and I can sort of settle down  
 15 NP: [mm  
 16 Pt: the mornings (.) I'm the same I mean sometimes it's really bad I  
 17 mean I: (.) get in out of bed eventually coughing (.) get into the car to  
 18 go off to work (-) .thh (.) you guarantee I've got such a coughing fit  
 19 NP: mm  
 20 Pt: coughin splutterin oh just really ba:d really  
 21 NP: °mm°  
 22 Pt: a:nd my throat's forever dry:: (.) uhm: I've just got the constant  
 23 tickle: (-) uhm: ((clears throat)) the: (.) the doctor had changed the  
 24 inhaler (.) from the brown one  
 25 NP: [°mm°  
 26 Pt: to the white powdered one  
 27 NP: yes  
 28 Pt: now: (.) I might be wrong but I think that irritates me even more  
 29 NP: okay  
 30 (-)  
 31 Pt: perhaps it's cos it's a dried powder I don't know I mean as far as I  
 32 know I'm .hh doin it the best I can properly: [(.) you know  
 33 NP: [mm (.) mm

The patient talks about her asthma symptoms which are not being effectively managed by her current regimen. She describes her symptoms and how they impact on her day-to-day life which includes the emotional impact. In extract 1, line 5, the patient said that she is 'fed up' with coughing all the time and in

extract two, line 1, the patient says *'it [asthma symptoms] just makes you miserable all the time'*. In response to the patient's latter emotional cue, the nurse validates the patient's emotional concerns when she says *'yes (-) yes (-) of course it does'* (Extract 2, line 2). The patient further elaborates and perhaps summarises how the unmanaged symptoms of asthma have impacted on her when she iterates *'I suppose it's affected my life in lots of ways really'* (line 3) which the nurse picks up on and offers an extended empathic response when she says *'well- in that case I think you know it doesn't matter how many times don't feel you can't come back because I think the important thing is that we try to get it balanced for you'* (line 4-6). The nurse's response reflects that she has been attentive to the patients' emotional concerns and the lifeworld experience of living with unmanaged symptoms while also providing reassurance that they will endeavour to find an approach to managing her symptoms more effectively. The patient agrees with the nurse's response by saying *'yeh (-) I think that's what it needs'* (line 7). The patient's agreement with the nurse perhaps reflects the degree to which the nurse has accurately attuned to her patient's concerns.

Extract 2: [12:14- 12:42]

- 1 Pt: *it just makes you miserable all the time you know*
- 2 NP: *yes (-) yes (-) of course it does ((typing))*
- 3 Pt: *I suppose it's affected my life in lots of ways really*
- 4 NP: *well- in that case I think you know it doesn't matter how many*
- 5 *times don't feel you can't come back because I think the important*
- 6 *thing is that we try to get it balanced for you*
- 7 Pt: *yeh (-) I think that's what it needs*
- 8 NP: *do you mind if I just look and see what they've given you cos*
- 9 *I don't want to go (-) back over old ground*
- 10 Pt: *[mmm (.) no of course not*

Conveying her understanding to the patient in this way is an example of positive emotional labour which reflects her attentiveness and ability to gauge how her patient feels while communicating this to her (James, 1992). This aspect of emotional labour reflects the way in which the nurse and patient are engaged in

a therapeutic and collaborative relationship and is a recognised hallmark of emotional labour applied within a healthcare setting (Theodosius, 2008).

The nurse uses the term 'we' when she says *the 'important thing is that **we** try to get it balanced for you'* (line 6) which suggests that the responsibility for managing her asthma more effectively is a shared responsibility and perhaps communicates that she is not alone in having to manage her symptoms. The journey is shared and communicating this to the patient is likely to reduce feelings of loneliness or isolation for the patient in her experience of managing an on-going health condition. As Suchmann suggested, being a recipient of empathic communication and having one's concerns understood 'bridges the isolation of illness' (Suchmann, 1997:678). Additionally, in communicating that she is not alone and in sharing the responsibility for making her well, the nurse's emotional labour may serve to foster a connectedness with the patient (Street et al., 2009).

In the third extract, later on in the consultation, the nurse and patient have agreed on a course of treatment, a change to the regimen. The nurse is reiterating the regimen to the patient at the beginning of extract three and provides a timeframe of one month to assess the effectiveness of the suggested change in treatment.

Extract 3: [21:41-22:09]

- 1 NP: ... same device as your blue one a:nd it's wh- uhm inhale (.) so two
- 2 puffs twice a day morning and evening
- 3 Pt: okay right I'll tr[y that yeh
- 4 NP: [we'll give you a month to try Jan
- 5 (.)
- 6 Pt: yeh
- 7 (.)
- 8 NP: and see how it goes fing[ers crossed
- 9 Pt: [definitely (things will improve) further cos
- 10 NP: yeah:

11 Pt: *it was just like (.) you know*  
 12 (.)  
 13 NP: *but do: (.) I mean don't feel you've got to put up with this because*  
 14 *you- you shouldn't there's enough out there that we can try(.) [and I*  
 15 *think if I takes us*  
 16 Pt: *[(to do:)]*  
 17 *a while so be it but we'll just try and-.hh*  
 18 Pt: *yeh*  
 19 NP: *and get it better for you [and hope it works*  
 20 Pt: *[yep that's uhm*  
 21 Pt: *that's brilliant*  
 22 NP: *good (-) have you got any questions*  
 23 Pt: *no (-) I think you've answered all my questions*

The nurse subsequently says to her patient in line 8 '*and see how it goes fing[ers crossed]*' as if to emphasise that the nurse is also invested in wanting the treatment to work. The nurse then encourages the patient to come back if she is still finding it difficult to manage her symptoms and that she should not have to tolerate her symptoms as there are courses of treatment available to her in order to help her manage her asthma more effectively– '*but do: (.) I mean don't feel you've got to put up with this because you- you shouldn't there's enough out there that we can try(.) [and I think if it takes us a while so be it but we'll just try and-.hh and get it better for you [and hope it works'*[lines 13-20]. Again, the nurse uses the term 'we' when she says '*there's enough out there that **we** can try*' and again '*but **we**'ll just try*' and similarly uses the term 'us' when she says '*if it takes **us** a while*' (lines 13-18). Again, this conveys to the patient that the nurse is committed to undertaking this journey with the patient.

Additionally, in line 4, the nurse uses the patient's first name. In naming her patient, it may have the effect of increasing familiarity and closeness, which is perhaps another approach of fostering a connectedness with her patient. Additionally, in using the patient's name it may serve as a way of reducing the formality of the consultation process and thereby putting the patient at their ease, and perhaps serving as a rapport building feature, as previous authors have highlighted (Chatwin et al., 2007). However, given previous evidence



which disconfirms the notion that familiarity can facilitate psychosocial disclosure and serve as a prerequisite for psychosocial support (Hill et al., 2013; Jabaaji, 2008), any conclusions regarding the familiarity of this nurse and her patient, need to be regarded cautiously.

The connectedness perhaps also conveys to the patient that the nurse cares and that she is invested in doing what she can in managing her asthma more effectively. Importantly, the patient's response, '*that's brilliant*' in line 20, is perhaps an indicator that the nurse's positive emotional labour has been heard and valued by the patient.

This exchange between nurse and patient characterises the way in which emotional labour is employed within a healthcare setting. The nurse manages and responds empathically to the patients biopsychosocial needs while the patient expresses gratitude and therefore supports the notion that emotional labour is not unidirectional. As Theodosius (2008) highlights this exchange of feelings recognises the more dynamic and relational nature of emotion labour theory and that within the healthcare context, there is a reciprocity in the exchange of feelings between the patient and professional (Theodosius, 2008).

Finally, in contrast with those examples of structured/script driven or task focused consultations that will be presented in the following section (part 2), this nurse manages to integrate the patient's biopsychosocial needs within the framework of an asthma clinic. Crucially, the consultation is not governed by the task of completing templates (in reference to QOF pro-formas which need to be completed) but is responsive to the patient's needs.

*From the diary: reflections on consultation 474*

The patient talks, the nurse listens and sounds like she genuinely cares – this was my first and lasting impression of this consultation. In listening to the myriad of consultations, I had become accustomed to the patient being interrupted early on in the opening of the consultation. As part of the Leverhulme study, we were interested in whether patients completed opening agenda items (their reasons for visiting) and when and how patients were interrupted in the consultation. Across the consultations, patients rarely

completed their agenda items and so this consultation immediately stood out in this respect alone. This patient's opening agenda was interrupted at 1.55 minutes while the average was 22 seconds for nurse prescriber consultations, 26 seconds for GPs and 28 seconds for pharmacists.

The other aspect of this encounter which stood out for me was that the consultation was patient led – the patient steered the consultation and the nurse was accompanying her on her journey, listening, and giving direction and information at timely moments. The nurse responds to the patient's agenda and is not guided by her own which contrasts with other consultations which appear to be more guided by the structure of a medication review or other review based clinics such as asthma or diabetes clinics. In contrast, this consultation differed in that respect as although the nurse is able to intercede using her clinical expertise and experience, and is able to gather relevant information along the way, she uses her experience of managing patients with on-going medical conditions and effectively integrates her own agenda with the patient's. As with consultation 313, the nurse seems to place the patient at the heart of the consultation and never loses sight of her patient's needs and concerns. Again, this consultation sounds unhurried, the patient is unrushed and there is time and space for her to talk and be heard.

### **Case C: Pharmacist Prescriber and Patient 593**

The patient has come in discuss the results of his blood sugar within a routine diabetes clinic. The patient and pharmacist discuss his diet in light of his high blood sugar results.

From the opening of the consultation, the male patient engages in light-hearted banter with the female pharmacist over the difficulties he is experiencing in changing his diet in order to manage his diabetes. Although the discussion appears light-hearted, it also hints at some of the frustration and difficulty involved in managing a chronic health problem and associated dietary changes required in managing diabetes. In this consultation the pharmacist

communicates understanding of these challenges whilst also relaying the importance of needing to make dietary changes in order to manage his diabetes. She balances a clinical response, often appearing to employ discourse associated with motivational interviewing, with an empathic response by acknowledging how challenging it is for the patient. The use of motivational interviewing in this encounter also reflects the patient centred nature of this consultation since motivational interviewing has been defined as 'a collaborative, patient centred form of guiding to elicit and strengthen motivation for change' (Miller and Rollnick, 2009: 130).

She also presents herself as non-judgemental and is adept at improvising in the healthcare encounter in order to engage with the patient who employs humour to perhaps downplay or background the challenges of needing to change his diet in order to manage his diabetes. This is not certain but evidence from the literature suggests that patients employ humour in different ways, in order to avoid shame or embarrassment or to distance themselves from embarrassing or uncomfortable situations (Salmon et al., 2004). This pharmacist employs positive emotional labour in the way that she is able to improvise in order to engage with the patient and develop a rapport with him – evidenced in the way she responds to the patient's banter and in the way she listens and is sensitive to the patient's experience.

The pharmacist's improvisation and use of humour with the patient is evidenced when she says '*I know (.) it's a miracle isn't it (laughs)*' (line 4) as her response to the patient who remarks about that the appointment was running early '*oh right and you're early too aren't you*' (lines 3-4). Later on in the consultation the pharmacist responds in good humour when the patient points out '*...I saw you at the co-op filling your face... you were quite embarrassed then weren't you*' (line 19-22).

The way in which the pharmacist engages with her patient is indicative of Hochschild's conceptualisation of two types of gift exchange: straight and improvisational. Hochschild defined the two exchanges, as follows: 'in straight exchange we simply use rules to make an inward bow .... in improvisational exchange, as in improvisational music, we presuppose the rules and play with them, creating irony and humour' (Hochschild, 1983:77).

This pharmacist is responsive to the patient's use of humour which is perhaps employed to downplay or divert from needing to discuss or address the more serious topic related to his diet. This use of humour or deployment of humour as a gift is also evidenced in Bolton's paper in which she describes nurses who use humour as a gift to communicate and connect with their patients. Bolton also described this use of humour in a theme entitled 'having a laugh' to demonstrate how nurses use humour to interact with their patients while also signalling the pleasure nurses gain from interacting with patients in this way (Bolton, 2000). In this consultation, it does appear or sound as if the pharmacist's use of humour and ability to improvise is serving to connect with her patient, perhaps facilitating and/or enabling a more serious discussion regarding the management of his diabetes. This echoes work undertaken by Jones and Collins who identified 'side conversations' (when the conversation switches away from clinical or task orientated) as an important facilitator of rapport building within the patient-professional relationship (Jones and Collins, 2007). Similarly, this pharmacist is able to engage with the patient on his terms and is also able to laugh at herself while taking the patient's concerns seriously.

After the initial banter subsides, the pharmacist attempts to engage the patient in serious discussion about his sugar levels. She informs him that his sugar levels of increased: *'this long term sugar test has gone up from 8.6% to 9.8%'* to which the patients responds to by making light of the cakes he has been consuming and subsequently recalls the moment when he witnessed the pharmacist 'stuffing her face' in the coop, as discussed earlier. The pharmacist then brings the consultation back to a discussion of his sugar levels when she says *'I know but it's the sugar basically your body can't handle sugar very well okay so'* to which the patient interrupts in line 28 and says *'it can't do much else to be honest with you.'* The pharmacist's acknowledges the patient by saying 'I know' before continuing to explain about the inability of the body to manage the excess sugar in the body to which the patient responds by saying *'I ought to be shot really, like a horse' (line 34)*. This response is said in jest but could hint at some of the underlying feelings about how the patient is coping with his diabetes. The pharmacist responds by saying *'don't be silly'* (line 35) reflects a jovial tone established by the patient from the outset of the consultation. I feel the pharmacist can get away with saying this because she knows her patient and is able engage with her patient on his level and demonstrates her ability to

adapt and improvise when required. Whether this skill comes naturally or not, the pharmacist is responding to her patient as a person.

### **Pharmacist Prescriber Patient 593**

#### Extract 1: [0.02-6.32]

*Inaudible chatter in first 2 seconds*

- 1 PhP: so yeh it's back this morning it actually just came back this
- 2 morning so (.) uhm
- 3 Pt: [oh right and you're early too aren't you
- 4 PhP: I know (.) it's a miracle isn't see (laughs)
- 5 Pt: it is (.) when I come in here for the blood they was five
- 6 minutes early I was in an out
- 7 PhP: [Laughs]
- 8 Pt: all the patients are on holiday that's what it is
- 9 PhP: well there you go we do try we do try (.) well actually the
- 10 patient before you cancelled so:: that's why
- 11 Pt: [oh right
- 12 PhP: .hh so basically your blood test has come back now (.) it's
- 13 has actually gone up, this long term sugar test has gone up from
- 14 8.6% to 9.8% so .hh
- 15 Pt: [that's all the cake I've been eating, all the Victoria
- 16 sponge cakes from Morrison's, they're very tasty (laughs)
- 17 PhP: ooh, is it, mmm. What else have you been eating, anything
- else
- 18 Pt: not really no, well I mean I did go for a trip of having Mars
- 19 bars and stuff like then but then I saw you at the co-op filling your
- 20 face
- 21 PhP: [laughs
- 22 Pt: you were quite embarrassed then weren't you. Anyway mm I
- 23 just had the cake and cornflakes I put sugar on them and I know
- 24 it's still sweet but it's just once a day isn't it and I put sugar in my
- 25 coffee
- 26 PhP: I know but it's the sugar basically your body can't handle

27 *sugar very well (.) okay so*  
 28 *Pt: I can't do much else to be honest with you*  
 29 *PhP: I know, by having the extra sugar on your cereal that's just*  
 30 *gonna make it harder really uhm and that's why you've got these*  
 31 *high levels of sugar circulating in your blood stream because your*  
 32 *body can't handle it, it can't get it stored away in your bodies' cells*  
 33 *and used as energy*  
 34 *Pt: I ought to be shot really, like a horse*  
 35 *PhP: No, don't be silly (..) so, the basics you need to be doing are*  
 36 *cutting the extra sugars out of your diet so actual sugar sugar and*  
 37 *changing over to sweetener*  
 38 *Pt: yeah*

These three cases illustrate the range of positive emotional labour employed within healthcare encounters. These aspects of positive emotional labour included instances of healthcare professionals who created space in the consultation for patients to talk while also demonstrating an attentiveness to and engagement with patients' biopsychosocial world. In some examples, professionals appeared to go the extra distance in conveying empathy, in offering reassurance to their patients or communicating their understanding of the patient's biopsychosocial concerns or needs. These facilitators of positive emotional labour were employed across the three professional groups.

The examples also reflect health care professionals who appear adept at integrating the patients' clinical needs with their psychosocial ones, and not losing sight of the patients' health and illness experience. The last case with the pharmacist shows a healthcare professional who is adaptable in the consultation process and is able to improvise as shown by her responsiveness to the patient's humour.

The following section will present the range of challenges, barriers and constraints which prevent or reduce opportunities for professionals to employ positive emotional labour within healthcare encounters. The section will also

discuss how these barriers impact on the way patients participate and communicate their emotional cues and concerns in the consultation process.

## **5.2 Challenges & Barriers to Positive Emotional labour**

In this section, I will present and discuss examples of encounters in which the following challenges and barriers to positive emotional labour have been identified:

- i. Emotional Disengagement – Keeping it Clinical
- ii. Task Focused Consultations
- iii. Agenda Driven Consultations

It is important to note that although the following cases provide evidence of some of the barriers or challenges to offering positive emotional labour, the consultations also contain elements of positive emotional labour at various times in the consultation. However, the consultations have been identified for inclusion in this section since the overall style of the consultation or barriers to the use of positive emotional labour occur repeatedly.

### **i. Emotional Disengagement – Keeping it Clinical**

The first barrier to the employment of positive emotional labour, emotional disengagement, was evident across the professional groups but was more commonly observed in GP consultations, particularly with male GPs. These findings are also reflected in the results of the proportion of positive/missed opportunities observed in phase one of the study. In these encounters, the ways in which GPs prevent a more person centred approach to the healthcare encounter is characterised in the way professionals appeared emotionally disengaged due to the lack of positive emotional labour. Disengagement was not necessarily explicit but exemplified often in what the professional did not communicate or when the professional did not engage with their patient on a more emotional level; namely lack of empathy in relation to the patients' emotional world or journey as expressed during the consultation or use of the

voice of medicine employed to perhaps deflect or defer from engaging on an emotional level, as has been identified in previous research (Zimmerman et al., 2007, Barry et al., 2001).

Examples of disengagement include consultations in which the professional does not communicate mutual understanding by attuning or engaging with the patient on an emotional or empathic level. This represents one of the key barriers to offering positive emotional labour such as empathy and the recognition of the emotionality expressed by the patient during the consultation. The following three cases, all male GPs, illustrate the varying ways in which professionals disengage on an emotional level during a healthcare encounter. With the exception of the GP (consultation 313) in section one 'Positive Emotional Labour', the inclusion of three consultations with male GPs reflects the tendency of GPs, within this sample, to maintain a clinical agenda which consequently disengages with patients' emotionality. The findings supports previous literature which highlight the gendered and professionalised aspects of emotional labour; that nurses care and doctors diagnose as previous authors have highlighted (Smith, 2012; Theodosius, 2008; Fineman, 2003).

#### **Case A: GP and Patient 454**

The first example is taken from a consultation between a male GP and a female patient. The patient iterates a number of cues and concerns relating to her experience of having had successive health problems and fears about having recently been informed about the possibility of having a benign brain tumour. While the GP goes some distance to reassure the patient using the voice of medicine, he does not always acknowledge her re-iterated concerns and fears concerning the recent news about having a suspected benign tumour, in addition to managing pre-existing health problems.

In the two extracts below, it shows the patient's repeated cues and concerns which express her possible distress and shock at receiving the recent news about the benign tumour. The recent news occurs within a context of having had an on-going history of successive health problems (shoulder injury and a recent referral for a colonoscopy). The patient indicates that she thought that her life



was resuming to normality as she felt she had been recovering well from her shoulder operation but she says that the news about the brain tumour '*hit me*' (line 7) and is clearly upsetting for her as she sounds like she is working hard to fight back tears (line 8-9). Her distress in relation to the bad news is evident when she apologises for being upset: '*I'm sorry, I'm really upset*' (extract 1, line 10) and later on in extract 2 when she says '*I came back and I just got so upset about it*' (extract 2, line 3).

On two occasions in extract 1, the patient communicates her disbelief in response to the news about the benign tumour. She says she '*I just can't- just can't believe all this*' (line 12) and again in line 17, she says '*I can't believe it*' reflecting her disbelief at hearing the news about a possible benign brain tumour.

#### Extract 1 [1.15]

- 1     *Pt: I mean I just feel I had so much wrong with my shoulder and the*  
2     *op which was- very successful*  
3     *Dr: Yeh*  
4     *Pt: Uh and I was just getting my life back again I mean last November*  
5     *I started- I joined the gym I mean I then go to the gym three times a*  
6     *week and suddenly all this has hit me. I'm being sent for a colonoscopy*  
7     *next month because I had these pains now, I've been, ... it's ridiculous,*  
8     *now this chappie (voice breaks, tries to hold back emotion), I'm sorry,*  
9     *I'm really upset, I went to get this hearing aid which I'm on, he said to*  
10    *me I think we should have a MRI scan, I think you've got a brain tu -*  
11    *((voice breaks , whisper)) I just can't- just can't believe all this*  
12    *(-)*  
13    *I just feel I'm a big bomp with a bomp on*  
14    *Dr: Mm*  
15    *(-)*  
16    *Pt: I mean I can't believe this*  
17    *(-)*  
18    *I mean he said- well he said all this he said all my hearing has gone*  
19    *down with a bomp which was what it was then (-) but then - and I*

20 *thought well this is just rubbish you know I'm perfectly alright I'm fit.*  
21 *But then he said have you banged your- have you had a bang on your*  
22 *head and I said no and then: of course I realised last October*  
23 *I had a tremendous bang on my head nearly knocked myself out*  
24 *Dr: Mm*

In extract 2, her anxiety in response to the news and disruption it appears to have caused to her recovery trajectory is evidenced when she communicates that she had been going to the gym and had '*got my life back again*' (line 4) after needing to put '*two years of my life on hold*' (line 6) which provide poignant cues about the meanings and significance of the recent news for her and the possible shock, fear and/or anxiety bound up in hearing further bad news which, as she indicates, has prevented her from resuming her day-to-day life.

#### Extract 2 [4.58]

1 *Pt: I realise I really feel I've got my life back again I'm going to the*  
2 *gym three times a week and you know and then this colonoscopy ... but*  
3 *then when I went last Tuesday, I came back and I just got so upset about*  
4 *it*  
5 *Dr: Mm*  
6 *Pt: I don't want to waste any more I've had - two years of my life on*  
7 *hold*  
8 *Dr: Mm*

In these extracts, the GP's minimal responses '*mm*' may demonstrate that the GP is listening but sounded disproportionate or out of tune with the concerns and anxiety being expressed by the patient. However, it could be argued that the GP responded, albeit minimally and therefore does indicate that he was listening and did not interrupt the patient. In addition, without access to visual data, we do not know what the GP was communicating non-verbally.

However, it is evident that during this consultation, the GP did not explicitly verbalise his understanding of the patient's feelings in response to the 'bad' news. The GP did not validate or normalise her distress or anxiety or communicate an extended empathic response which may have conveyed his understanding of the patient's psychosocial world. Furthermore, there was an absence of positive emotional labour in response to the patient when she sounds audibly distressed or upset as evidenced in the first extract when she fights back tears and later apologises for crying. As a result, the GP appears emotionally disengaged from his patient who appears vulnerable as there is little evidence of the doctor employing emotional labour to manage the emotional needs of his patient but rather disengages from this process by keeping it clinical, by offering reassurance by employing the voice of medicine.

### **Case B: GP and Patient 115**

In the second example, a female patient has made an appointment with the GP because she is concerned about a protracted respiratory tract infection for which she has previously been prescribed several courses of antibiotics. She is also concerned that the most recently prescribed antibiotics have caused her to feel unwell. In response, the GP wants to send a sputum sample off to see if the patient has an infection which requires antibiotic treatment yet in the process overlooks the patient's concerns about the on-going infection. The GP's emotional disengagement is particularly evident when the GP sounds dismissive in response to the patient's repeated cues and concerns about her on-going illness and feeling unwell.

In extract one, the patient informs the GP that the antibiotics are 'not suiting me' and subsequently explains that she feels unwell as a result of taking them. The patient communicates that her doctor (a different doctor) is normally careful about what antibiotics she prescribes as she is aware that the patient is taking *warfarin* and *digoxin* (and therefore contraindicated with specific antibiotics). It appears that the patient is trying to work out why she may have reacted to the antibiotics as her doctor is careful in what she prescribes. The patient then continues to explain that '*when I mentioned it to the chemist uhm she said*

*digoxin didn't come up on her: (.) uhm:'* (line 19-20) at which point the GP interrupts the patient by saying *'the point being the medication's not suiting you Mrs Towers yeh'* (line 22) to which the patient agrees in saying 'yeh'. The doctor sounds impatient when he interrupts the patient and is indicative of the style of consultation he employs throughout. In contrast with consultation 313, for instance, the GP does not appear to provide sufficient space in the consultation to enable the patient to communicate her concerns and neither does he validate her worries around her illness or reaction to the antibiotic. One of the notable observations about this opening sequence is the GP's lack of emotional engagement with the patient – in this sequence and throughout the consultation there appears to be a lack of empathy in response to the patients initial concerns about feeling unwell as a possible consequence of taking antibiotics nor her other concerns about her chest infection. Furthermore, it is possible to hear that the patient's breathing is slightly laboured throughout the consultation and we know that the patient has an underlying heart condition for which she is taking warfarin and digoxin. Consequently, the GP's interruption, subsequent lack of empathy and by maintaining the consultation on a clinical level in response to Mrs Brewer's cues and concerns, suggest that this GP has not employed the emotional labour necessary to be able to attune and engage with his patient on an emotional level.

#### GP Patient 115

##### Extract 1

*From opening*

- 1     *GP: what can I do you this morning*
- 2     *((sound of writing))*
- 3     *Pt: I started those yesterday I've had three*
- 4     *(-)*
- 5     *Pt: they're not suiting me*
- 6     *GP: in what way:*
- 7     *(.)*

8 Pt: uh:m (-) .hh hhh unsteady on my feet (.) .hh feel sick (.) don't feel  
 9 at all well (.)an I know that- (.) you know hh since I've taken those .hh  
 10 when I need antibiotics doctor brewer is very careful what she gives  
 11 me  
 12 GP: hh hhm yeh  
 13 Pt: and then huhh! (.) uhm I've got that little note there which of  
 14 course you'll be very familiar with (.) that note there  
 15 (-)  
 16 GP: yeh okay yep mhm yep  
 17 Pt: [(you know ) on the on the instructions said (.)  
 18 people with warfarin: (.) had to be very careful and people on digoxin  
 19 (.) and when I mentioned t to the chemist uhm she said digoxin didn't  
 20 come up on her: (.) uhm: hhh (.) whatever it was her  
 21 GP: the point being the medication's not suiting you Mrs Towers yeh  
 22 Pt: yes

The patient's concerns arise several times in extract 2 and throughout the consultation. For instance the patient indicates that '*the phlegm's getting worse*' (line 1) and '*the breathing isn't as good as it was (.) either*' (line 17) and asks '*but- (.) what about this infection in my left lung will it- (.) go on getting worse*' and '*I don't usually cough anything up at all*' (line 25). The repeated references to her symptoms may suggest an underlying anxiety about her protracted illness; that she is concerned about the infection and coughing up phlegm and observes that this is unusual. Midway through this extract, the patient says '*but I'm- I'm- the breathing isn't as good as it was (.) either*' (lines 17). The GP sounds distracted at this juncture as he offers no verbal response and it is possible to hear the sound of writing – possibly the GP writing the patient's details on the sputum sample container. When the patient enquires about her chest infection in asking '*but- (.) what about this infection in my left lung will it- (.) go on getting worse*' (line 20-21) there is a pause and the sound of writing continues and subsequently the doctor responds by reiterating his justification for sending of a sputum sample to ascertain whether or not there is an infection present.

The patient's re-iteration of her symptoms suggests that she is looking for reassurance and perhaps reflects an existential anxiety about her lung infection. This is not certain but previous research indicates that the prescription can sometimes be offered as a poor substitute for meaningful interaction which is more valued by the patient. Over and above the act of issuing a prescription, patients value doctors who demonstrate patient centred qualities and behaviours such as being attuned, attentive and taking the time to listen to their patient and take their concerns seriously (Wartman et al., 1981). This patient has been prescribed several courses of antibiotics in previous consultations and perhaps she was looking for empathy and reassurance in this (and in previous) consultations. If this is the case, it appears that the patient was not offered what she may have needed.

*Extract 2*

- 1 Pt: I think the phlegm's getting worse  
2 GP: .hhh well let's see it (-) let's send something off tomorrow and grow  
3 something if there is something yeh  
4 Pt: [mmm  
5 (-)  
6 GP: because that would te- tell us what if anything is there and what if  
7 anything we should give you (.) yeh  
8 Pt: yeh  
9 GP: rather than just muck around poisoning you with something  
10 different again today: cos we're clearly doing you more harm than good  
11 with some of these antibiotics  
12 Pt: [yeh  
13 GP: aren't we yeh  
14 (-)  
15 Pt: we- well ye:s (.) you are:  
16 GP: yeh  
17 Pt: but I'm- I'm- the breathing isn't as good as it was (.) either  
18 GP: [((sound of writing))  
19 (-) ((writing))

20 Pt: *but- (.) what about this infection in my left lung will it- (.) go on*  
 21 *getting worse*  
 22 *(-) ((writing))*  
 23 GP: *well- (.) m- Mrs Brewer c- can we see if there is one first yeh rather*  
 24 *than just be- he- rather than: just giving you more antibiotics*  
 25 Pt: *[yeh I don't usually cough anything*  
 26 *up at all*  
 27 GP: *w- w- d- I- I hear what you say I hear that there's an: a- you're*  
 28 *coughing stuff up*  
 29 Pt: *yeh*

While the doctor's decision to send off of a sputum sample makes clinical sense and importantly, appears to make sense to the patient, he nevertheless overlooks her expressed cues and concerns about her on-going illness and possible need for reassurance. His lack of reassurance and empathy is exemplified in his response to her concerns when he says: *'rather than just muck around poisoning you with something different again today: cos we're clearly doing you more harm than good with some of these antibiotics'* (9-11). Furthermore, the GP sounds impatient - these interpretations derived from the prosodic cues such as the tone of voice which inform the listener about how the doctor sounds in the consultation. Throughout this consultation the patient's reiterated cues and concerns about the protracted illness remain largely ignored. This consultation contrasts with consultation 313 in which we saw a GP who was emotionally engaged with his patient as evidenced in his extended emotional labour which validated and conveyed understanding of the patient's illness experience.

Finally, this doctor employs a similarly abrasive consultation style in other consultations which suggest that rather than trying to attribute the doctor's consultation to an unknown back story relating to the patient (for instance, a frequent visitor, or a patient who demands antibiotics), it provides further evidence that the doctor's emotional disengagement may be attributable to his style of consulting.

*From the diary: reflections on consultation 115*

My initial and lasting impression of this consultation was of the way in which the GP managed the patient's concerns about her chest infection – he sounded patronising, dismissive and impatient. I even felt angry and frustrated because it sounded as if the GP just wanted to get rid of the as soon as he could. I wondered if I was being too hard on the doctor because I do not know the background to this consultation or wider context of this consultation. Was this patient a frequent visitor? Was the patient expecting to be prescribed antibiotics? However, this was disconfirmed when listening to the majority of his consultations which showed a similar style.

I felt that the patient's concerns were not really listened to. I felt the patient had been given a rough deal as I wondered why she had been given several courses of antibiotics without necessarily assessing whether or not the cause of her symptoms were bacterial or viral. Had the patient demanded antibiotics or had she been fobbed off? Perhaps she was simply looking for reassurance. We don't know. Despite the unknowns, I instinctively compared this consultation with 313 in which the GP sounded more empathetic.

### **Case C – GP and Patient 252**

In this consultation, evidence of emotional disengagement appears in response to the patient's concerns about medication side effects. In this consultation, a male patient communicates several cues relating to the side effects of his medication used to maintain bladder function which has been affected by previous treatment received for prostate cancer. This patient communicates that the medication he is using '*remove[s] my brain*' (line 1) and he finds himself '*turning into a: sit in the chair and watch the telly forever*' (line 4-5). Despite communicating these concerns about the side effects using such vivid imagery about the medication removing his brain, the doctor responds minimally and without acknowledging the significance and impact of the side effects for the patient. The absence of positive emotional labour is evident when the doctor does not validate or explore the patient's concerns about the side effects and



appears to side step the issue by directing the patient to a website 'patient.co.uk' for information relating to this particular medicine. Similar to the previous consultation, the patient's concerns remain unacknowledged and unexplored during the consultation.

Extract 1 [07:52]

- 1 Pt: *we:ll most of those things remove my brain*  
2 (-)  
3 Dr: *right.*  
4 Pt: *and I find myself turning into a: sit in the chair and watch the telly*  
5 *forever rather- rather often*  
6 Dr: *right (.) so I'll give you some fives to try, if that's not effective you*  
7 *Can increase it to two*

These consultations in section three perhaps illustrate that while the healthcare professional may be attending to the clinical needs of their patients, the patients psychosocial needs may be overlooked. In addition, in contrast with the previous section, it is evident that time and space was not always created to enable patients to talk and professionals to listen and communicate understanding.

Disengagement with the emotional aspects of healthcare encounter may occur for a number of reasons and has been discussed in the literature section. Perhaps healthcare professionals do not engage on an emotional level and employ clinical discourse as a shield to deflect emotions or defend against those emotions which professionals feel unable to manage or are challenging to engage with (Fineman, 2003; Kleinman, 1998). It is possible that disengaging occurs unintentionally and perhaps unconsciously but which can result in the myriad of patients' feelings (such as worries, fears, distress, about an illness or symptoms) remaining unacknowledged, unexplored and unmet.

It is only possible to speculate on why professionals may be disengaged on an emotional level and why there is an absence of positive emotional labour

employed by some healthcare professionals. The literature points to a number of reasons to account for these barriers to emotional labour and may be partly attributable to the varying provision, emphasis and/or value placed on communication skills training across the professional groups. It may also be accounted for by the way in which specific professional groups such as doctors are socialised or expected to behave/feel in a certain way – those feeling rules for doctors may influence the way doctors are expected to feel. It has been argued that due to the way in which doctors are socialised in their training, they are expected to be/feel rationally, in control and therefore potentially distanced or uninvolved in others' emotional realities (Theodosius, 2008; Fineman, 2003).

It is argued that medics, in particular although not exclusively, acquire the 'cloak of competence' early on in their medical careers and perform to appear invulnerable to the myriad of human emotions that they encounter on their professional journey (Haas and Shaffir, 1987). To keep up this appearance, it has been observed that doctors employ a range of strategies to manage emotions – such strategies include the (over) reliance on the medical model which serves to distance and to deflect or protect the professional's own anxieties or lack of confidence in knowing how to respond to patients' emotions (Kleinman, 1998). Such strategies result in professionals distancing themselves from their patients which consequently prevent them from engaging with their patients on a more emotional and compassionate level (Fineman, 2003; Baker et al, 1994). Furthermore, the denial of feelings and emotional disengagement from their patients and themselves can lead to a sense of isolation for the professional concerned, reduced job satisfaction and an increased likelihood of stress and burnout (Zapf & Holz, 2006; Williams, 2012).

## **ii. Task Focused Consultations**

The second barrier or challenge to positive emotional labour is evident in task focused consultations. Task focused consultations are typified by encounters in which the professional is distracted and therefore less attentive when they are attending to or completing certain tasks in the consultation (for example, taking blood pressure, temperature, examining the patient, typing or printing a

prescription) and which have two principal effects on the patient. Firstly, the patients may have limited opportunities to express their emotional cues and concerns due to the reduced opportunities to participate in the consultation. Secondly, when/if patients express concerns, professionals may not employ positive emotional labour such as offering an empathic response because they are distracted or focused on the task at hand. Consequently, patients' expressed concerns remain unexplored or ignored while unexpressed concerns remain unspoken and subsequently and similarly unexplored and unacknowledged.

The following cases are explored:

- Case A – Nurse Prescriber Patient 236
- Case B – Nurse Prescriber Patient 92
- Case C – GP Patient 281

### **Case A – Nurse Prescriber Patient 236**

The next example depicts a consultation between a nurse prescriber and an elderly female patient (236) who presents with on-going flu like symptoms and is specifically concerned about her constricted breathing and possibility that she had contracted swine flu. From the outset, the patient indicates that she does not want a further course of antibiotics as she is going in to hospital to have a knee replacement. She then justifies this by saying that *'I don't want to be sort of: be low to pick up anything' (line 5)*. The nurse agrees and offers minimal responses during the opening of the consultation when she says *'that's right' and 'yeh'*.

The consultation sounds very rushed which is reflected in the way the patient's narrative is frequently interrupted by the nurse's interjections. On listening to the consultation, the patient is attempting to communicate her concerns and worries yet with reduced space or opportunities for doing so. The patient's cues and concerns are raised amidst the tasks being undertaken by the nurse who does not appear to provide the patient with time and space to talk and listen.

This contrasts with a previous consultation between another nurse and her patient (474) in part one in which the nurse provides the patient with ample time and space which enables the patient to voice her concerns about her asthma and how it impacts on her.

In this extract below, the patient conveys a range of cues and concerns relating to worries she has about going in to hospital to have knee surgery, and concerns about the having had swine flu. The patient also iterates several cues about difficulties she has had getting out and about due to the snow and ice, for instance, she says: *'but I haven't been out of course .hh uhm- Saturday was my first day out'* (line 17) to which the nurse responds by asking her *'nno: so you're not coughing up anything else any more'* (line 18).

### **Nurse Prescriber Patient 236**

#### Extract 1 [00:07]

- 1 Pt: I don't really want to have any more antibiotics because you see
- 2 I've got to go and have this knee replacement
- 3 NP: [that's right
- 4 NP: yeh
- 5 Pt: and I don't want to be sort of: be low to pick up anything
- 6 NP: [no
- 7 NP: no exactly
- 8 Pt: so I'm going now to get a probiotic yoghurt cos that is very good,
- 9 NP: [great
- 10 Pt: isn't it
- 11 NP: it is (.) yep
- 12 Pt: but I haven't been out of course .hh uhm- Saturday was my first
- 13 day out
- 14 NP: ri:ght
- 15 Pt: but I mean that's partly the snow or ice as well that I daren't
- 16 NP: [yes
- 17 Pt: ( )
- 18 NP: nno: so you're not coughing up anything else any more
- 19 Pt: well I'm still bringing up but not that awful gree:n that I was

20 *bringing up*

21 NP: *[good*

22 *and of course I was using paper hankies I wasn't swallowing it or*

23 *anything*

24 NP: *right. (-) and do you feel tight*

25 Pt: *[I still feel tight ye:s*

26 NP: *right. Okay – can you just pop your coat off . . .*

27 NP: *and you haven't got an inhaler have you*

28 Pt: *I haven't no*

29 NP: *no (.) okay*

30 *(-)*

31 Pt: *I've never had something like thi:s but I don't know was it swine*

32 *fl(hh)u(hh) heh*

33 NP: *(>let me<) just have your finger to begin with*

34 Pt: *oh ri:ght*

35 NP: *have you ever smoked*

36 Pt: *no, never*

In the final part of this excerpt, lines 31-32, the patient communicates that she may have had swine flu due to the unprecedented severity of her symptoms to which the nurse prescriber responds by firstly asking the patient for her finger and secondly, by asking the patient if she smokes. The nurse appears very task focused and addresses the patient's biomedical concerns without necessarily attending to, acknowledging or validating the patient's psychosocial worries or offering reassurance to the patient's underlying concerns about whether or not she has had swine flu. As a result, the question '*have you ever smoked?*' as a response to the patient's concerns about swine flu sounds discordant and out of tune with the patient's verbalised concerns. The nurse does not address the patient's concerns about having had swine flu despite the patient having had raised this concern several times during the course of the consultation. Furthermore, unlike previous consultations, this nurse does not appear to improvise or divert from her tasks in order to engage in side conversations which foster connectedness and rapport between patient and their healthcare professional. In attending to her tasks, it appears that the nurse is disengaged

with her patient and consequently reduces opportunities to foster a therapeutic relationship with her patient.

From the diary: reflections on consultation 252

My impression of this consultation was of a nurse who appeared very task focused, distracted and inattentive to the patient's concerns. The consultation was under 5 minutes and so I felt that the nurse would have time to offer her patient more time and space. The nurse was running to schedule and therefore there seemed no obvious reasons to explain the rushed nature of the consultation – this was particularly indicative of this nurses' consultation style and when listening to the consultation I just wanted to say slow down – take your time, and listen.

### **Case B – Nurse Prescriber and Patient 92**

It should be noted that this consultation bridges the theme between task orientated and structured consultations. Case B is taken from a consultation between a nurse prescriber and female patient who is taking medication for wide-ranging chronic health problems. During the consultation the patient communicates a range of cues and concerns relating to those health conditions. The nurse appears to be focused on adhering to the asthma review script, is task focused and often appears distracted. Being task oriented perhaps narrows opportunities to employ positive emotional labour while the nurse appears inattentive and does not therefore attend to the patient's cues and concerns relating to the patient's iterations relating to on-going health problems.

In Extract one, lines 1-5, the patient divulges a catalogue of health problems to the nurse: *'...I've now started getting: uhm really awful migraines that come around my period so I get asthma, a migraine (.) I (.) vomit my period.. bu:t (.) since the end of September I haven't had a period... and they've been horrendous they have been horrendous'*. The nurse is focused on taking her blood pressure as we can hear the sound of the sphygmomanometer being pumped up. The nurse sounds distracted and rather than reply to the patient's health concerns she responds by saying *'that's good, that's good'* (line 8) which

may be in reference to her blood pressure readings but which do not specifically attend to, acknowledge or respond to the patient's cues.

## **Nurse Prescriber Patient 92**

### Extract 1 [09:05]

- 1 Pt: *[that's the new one and then also I've now*  
2 *Started getting: uhm really awful migraines that come around my*  
3 *period so I get asthma, a migraine (.) I (.) vomit my period.*  
4 *(-)*  
5 Pt: *bu:t (.) since the end of September I haven't had a period*  
6 *((sound of sphyg being pumped up))*  
7 Pt: *and they've been horrendous they have been horrendous*  
8 NP: *that's good that's good*  
9 *((sound of air being released from sphyg))*  
10 NP: *that's fine*  
11 Pt: *it's been like xxxx*  
12 NP: *ohh*  
13 Pt: *it's just that cos the- my bones are all to pot now .hh that's what*  
14 *I'm really suffering with in my back*  
15 *(-)*  
16 NP: *n- you've been on uhm (prednisolone) daily for*  
17 Pt: *donkeys*  
18 NP: *years and years yeh*

Similarly, in extract two, the patient communicates further information about her health when she says '*it's just that cos the- my bones are all to pot now .hh that's what I'm really suffering with in my back*' (lines 1-2) to which the nurse responds with the voice of medicine by saying '*n- you've been on uhm (prednisolone) daily for...*' (line 4) and the patient completes her sentence by saying '*donkeys*' (line 5) to imply a long time. The patient then explains that '*I have regular cord( ) epidurals and I had one in May and another one now: ... .. but I do need*

*surgery on my back .hh this joint's gone in my ( ) now'* (line 7 and 10) to which the nurse responds minimally by saying 'yeh yeh'. The nurse subsequently summarises as when closing the consultation and says '*other than that you're keeping- doing well'* (line 4) to which the patient concurs positively by saying '*really well... and now I've got to go back and finish my twelve hour shift'* (lines 15-16). It is only possible to speculate why the patient agrees with the nurse in her summary but perhaps the patient is colluding with the nurse in downplaying the extent of her health problems as a coping mechanism and perhaps the use of irony by both nurse and patient serves as a device for managing the situation.

### Extract 2

- 1 Pt: *it's just that cos the- my bones are all to pot now .hh that's what*  
2 *I'm really suffering with in my back*  
3 (-)  
4 NP: *n- you've been on uhm (prednisolone) daily for*  
5 Pt: *donkeys*  
6 NP: *years and years yeh*  
7 Pt: *I have regular cord( ) epidurals and I had one in May and*  
8 *another one now:*  
9 NP: *yeh*  
10 Pt: *but I do need surgery on my back .hh this joint's gone in my ( )*  
11 *now*  
12 NP: *yeh yeh*  
13 Pt: *so::*  
14 NP: *other than that you're keeping- doing well*  
15 Pt: *really well*  
16 Pt: *and now I've got to go back and finish my twelve hour shift*

Throughout the consultation, the nurse appears very task focused and does not therefore deviate from her medication review script or improvise in response to the patient's wide-ranging cues and concerns relating to her health problems. By



being focused and engaged with her clinical tasks, there is an absence of positive emotional labour, perhaps typified by the nurse who appears inattentive to the patient's range of cues and concerns while she is focused on completing her clinical tasks. There is an absence of the attentiveness which was evident in previous consultations in which we saw, for instance, an empathic nurse who was attentive to the patient's experience of living with asthma. This nurse has not communicated to the patient that she has understood what it may be like having to manage her wide ranging health concerns and her inattentiveness to her emotional concerns lack the display of positive emotional labour seen in earlier consultations.

*From the diary: reflections on consultation 92*

I recruited this patient into the study and she told me she was a staff nurse working in a local hospital. I therefore wondered to what extent this factor played a part in the way she was managed by the nurse prescriber during this consultation. Were the patient's psychosocial needs overshadowed by her status as a healthcare professional where assumptions were made about her capacity to cope? The nurse's approach to the consultation was also indicative of other consultations in which the nurse's structured consultation style appeared to both preclude patients from participating and perhaps prevented the nurse from engaging and responding to her patients within a more patient centred approach. Perhaps the demands of conducting a review were overriding or preventing her from engaging with her patients on a more personal level.

**Case C: GP Patient 281**

While this consultation could also be included under the theme of 'emotional disengagement', it has been included in this theme to demonstrate that task focused consultations are not restricted to nurse consultations. This extract typifies the consultation style of this GP – the consultation is very clinical, the doctor performs tasks and gathers clinical information from the patient. The

patient is frequently interrupted by the doctor and the patient's cues and concerns are often met with a clinical response.

In lines 2-14, the female patient iterates a concern about feeling bloated when she says *'well with all the diarrhoea I've been getting you'd think I'd been losing weight but I don't seem to be gett[ing< I'm quite bloated'.... thank God for stretchy jeans that's all I can say >at the moment< cos it really- you know- (-) having diarrhoea all the time you'd think I'd be losing weight but...'*. At this point the doctor interjects in line 15 to relay the pulse reading *'mmm [(-) okay so your pulse is a hundred and four toda:y.'*

The patient raises this cue when the doctor is taking her pulse and consequently the doctor is preoccupied with this task. While this may be an untimely moment for the doctor, it may represent a timely opportunity for the patient to voice her concerns while there is space in the consultation to talk. The doctor's response to the patient's concern about bloating relates to the pulse reading *'mmm [(-) okay so your pulse is a hundred and four toda:y .hhh (-) ah hhh so..'*. While it is understandable that the doctor is distracted, the patient's concerns remain ignored or overlooked.

## **GP Patient 281**

### Extract 1 [02:18]

1. GP: ((taking pulse))
2. Pt: *well with all the diarrhoea I've been getting you'd think I'd*
3. *been losing*
4. *weight but I don't seem to be gett[ing< I'm quite bloated*
5. GP: [mmm
6. *[you know my- face gets quite bloated and my stomach gets: really-*
7. *quite*
8. GP: [mmm
9. *bloated as well*
10. GP: mmm
11. Pt: *thank God for stretchy jeans that's all I can say >at the*

12. *moment< cos it really*
13. *you know- (.) having diarrhoea all the time you'd think I'd be losing*
14. *weight but*
15. *GP: mmm [(-) okay so your pulse is a hundred and four toda:y*
16. *.hhh (-) ah hhh so*
17. *Pt: [hhhh*
18. *that (.) a hundred and fi(hh)ve so that's no better than when you*
19. *increased the*
20. *atenolol to fifty milligrams did you:*
21. *(-)*
22. *Pt: uh yeh (>it's like-<) twenty five yeh two a day*
23. *GP: two of those*
24. *Pt: one in the morning an one in the evening I've been [taking*
25. *GP: [okay well you can*
26. *increase*
27. *no:w to seventy five- (.) by the way you can take them all at once*
28. *Pt: right okay that's: hh*
29. *GP: uhm:*
30. *Pt: that's okay*
31. *GP: so that's ((starts tapping keys))*
32. *Pt: I've always- taken them both at the same time but then*
33. *when I've started*
34. *taking those (look) I changed- [(.) cos I was taking one on the night*
35. *of those one*
36. *in the*
37. *GP: [okay: ((tapping keys))*
38. *Pt: morning and one on nights [so (as I would for the)*
39. *GP: [right (-) I'll test this:*

The patient tries to make light of her concern in line 11 when she says '*...thank God for stretchy jeans that's all I can say ...*' yet the concern is raised later in the consultation which suggests that feeling bloated whilst having diarrhoea is troubling her.

The reiterated concern later in the consultation [5.01] is raised as a question to the GP *'is there any reason why my stomach does get bloated'*. This reiterated concern suggests that the patient is concerned about being bloated and the doctor offers a clinical response as she suggests that the bloating could be related to liver damage caused by her previous high alcohol consumption. While the doctor offers a biomedical explanation for the bloating, the patient's concern is not acknowledged by a more compassionate nor empathetic response which would offer reassurance or understanding of the patient's experience.

This extract also shows the way in which the GP frequently interrupts the patient, often in the process of gathering clinical information, whether it be interrupting the patient's narrative or interrupting opportunities for participation through the sound of typing at which time the doctor will be distracted and her attention diverted away from the patient.

It is reasonable and understandable that health care professionals will need to undertake clinical tasks during the consultation. While it may not be feasible to respond to patient's cues and concerns in the moment, it may be feasible to attend to or re-visit patients' concerns at another juncture in the consultation. As these extracts have demonstrated, patients communicate important cues and concerns during the consultation process and yet these are not always managed empathetically or explored. Previous research suggests that patients often communicate cues and concerns when professionals are undertaking tasks because it is seen as an opportunity in the consultation process to communicate or participate (Jones and Collins, 2007). While this moment may not be timely for the professional when they are focused on the task at hand, it emphasises the importance of creating opportunities for patients to voice their concerns throughout the consultation. If professionals are attuned to patients and aware of iterated concerns during those 'quiet spaces' in the consultation process, they may be more inclined or aware of the importance of returning to those concerns at a more timely moment and as Frankel remarked 'patients feel grateful when they have an opportunity to be heard and listened to' (Frankel, 1995:224).

### **iii. Process Driven/Structured Consultation Styles**

In this style of consulting, encounters are typified by the way in which a professional structures and directs the consultations with topics and questions, often closed questions, for the purpose of completing a computer template or in order to meet their own (biomedical) agenda. These formulaic styles of consultation therefore influence the way in which the consultation is delivered – the structured nature of such consultations therefore becomes more mechanistic and process driven as opposed to humanistic or person centred which would enable patients increased opportunities to participate and express their ideas, needs, concerns and expectations.

This theme is distinguishable from the previous section on 'Task Focused Consultations' due to the influence of the professionals' agenda and need to complete a pre-determined set of questions. Although subtly different the consequences for the patient are similar – namely, that patients may have reduced opportunities to express themselves and that because professionals are preoccupied with the task of completing the template, they are less likely to offer a patient centred approach.

These types of consultations are most notable in encounters between pharmacists and nurses, in which the professional appears to follow a more structured pro formulaic consultation style in which the professional directs the consultation by asking a series of closed questions –the professional is steering the consultation towards a clinical agenda, mainly for the purpose of completing a clinical template. With this focus, some professionals are prevented or unable to respond to or incorporate the patient's needs, ideas and concerns. In these consultations, there is little evidence of professionals' improvisation in which the professional can adapt to patients' needs or concerns rather than pursue their own agenda. Being able to adapt and improvise in the consultation is a skill and is useful in being able to connect with or attend to the patient's agenda and notably their emotional cues and concerns. This style of consultation contrasts with those consultations in which professionals are able to integrate patients' concerns and needs into the consultation process while also meeting the clinical demands. These consultations are less oriented by the professionals' agenda when compared to the more process drive or structured style of consultations.

The structured format which predominantly employs closed questions or questions which pursue an expected response, reduce opportunities and space for patients to voice their concerns. Furthermore, there appears less opportunity for the patients' concerns to be acknowledged, explored and understood. While there are arguably clinical benefits to gathering this type of information for a medication review or in a diabetes or asthma clinic, for instance, it can have disadvantages for both parties. Narrowing opportunities to communicate may foreclose opportunities to gather or listen to important biopsychosocial information. Employing a structured consultation with closed questions which are predominantly driven by the professionals' agenda can also narrow opportunities for the patient to raise concerns, questions, ideas about aspects of their illness/condition or treatment. In reducing opportunities for patients to raise concerns or to express their needs, professionals may therefore foreclose opportunities for gathering relevant information relating to the clinical and wider psychosocial aspects of a patient's life. While gathering clinical information may sometimes be prioritised over and above psychosocial concerns (in an emergency for example), it is nevertheless important to emphasise the importance of identifying and responding to patients' cues and concerns which, when explored, may yield useful clinical and psychosocial information.

A further consequence of this style of consultation is in the way it reduces opportunities for the development of a patient-professional relationship since those side conversations (Jones & Collins, 2007) or improvisational aspects of the conversation are reduced when the focus of the consultation centres on completing the template. The following cases illustrate how this style of consultation forecloses a patient centred approach to the consultation and opportunity to respond with positive emotional labour:

- Case A: Pharmacist Prescriber Patient 358
- Case B: GP Patient 63
- Case C: Pharmacist Prescriber Patient 1050

## Case A: Pharmacist Prescriber Patient 358

The following extracts are taken from a consultation with a female pharmacist and female patient. This is an example of a structured consultation which is characterised in the extracts below in which the pharmacist uses a series of closed questions which forecloses opportunities for the patient to express their ideas, concerns and expectations.

From the opening of the consultation, the pharmacist introduces herself and explains that the patient has been referred by the doctor. The pharmacist does not enquire about how the patient is feeling nor does she invite questions or concerns from the patient at the opening, during or at the close of the consultation as is recommended by health educationalists (e.g. Silverman et al., 1998; Marvel, 1999). Instead, the pharmacist asks the patient if she has ever smoked to which the patient responds by saying she did but when she was younger – the pharmacist continues to pursue information about when the patient ceased smoking and other information relating to the patient's smoking frequency.

### Pharmacist Prescriber Patient 358

[00:10-00:22]

#### Extract 1

- 1 *PhP: ...I'm a pharmacist prescriber*
- 2 *Pt: mm*
- 3 *PhP: that deals with the lungs okay*
- 4 *(.)*
- 5 *PhP: you have actually been referred to me by: uhm: Doctor Cressman*
- 6 *Pt: Doctor Cressman yes:*
- 7 *PhP: an:d you saw her uhm: with breathlessness*
- 8 *Pt: mm=*

9 PhP: =correct  
10 (.)  
11 PhP: have you ever- (.) do you smoke  
12 Pt: when I was younger (.) when I was a teen  
13 PhP: so (.) how long ago did you give up  
14 Pt: oh I gave up because I started having bronchitis (..) I had to give  
15 up

In the second extract the pharmacist asks the patient to do a lung function test using a spirometer to assess her lung function. The patient describes her difficulties breathing when she says 'well I noticed I don't- (.) deep- (.) take deep breaths... I couldn't (0.6) breathe (.) deep enough' (lines 4-5) and later when she says 'because I feel heavy' (line 8) referring to her chest. The pharmacist does explore how this may be impacting on her day-to-day life nor offer an empathic response to acknowledge or validate the patient's reality.

Extract 2 [07:33-07:51]

1 PhP: ((calibrating the machine))  
2 Pt: well I noticed I don't- (.) deep- (.) take deep breaths  
3 PhP: yeah  
4 Pt: so as I was coming I couldn't (0.6) breathe (.) deep enough  
5 PhP: it's good to take deep breaths  
6 Pt: [( )]  
7 PhP: yeah: try an-  
8 Pt: really because I feel heavy  
9 (.)  
10 PhP: yeah (.) an it's- (.) the chest tightness isn't it  
11 Pt: [mm (.) mmm  
12 PhP: okay (.) so let's do this again okay so deep breath in



Similarly, in extract three, the pharmacist reads out five statements which are intended to ascertain the extent of the patient's breathlessness. The patient is invited to choose one of the statements as part of the assessment. Subsequently, the pharmacist asks the patient to '*describe the pain to me please (.) so where are you getting the pain*' (line 8). The patient responds with a long pause and then proceeds to describe when she experiences the pain rather than where she experiences the pain. The patient indicates that she experiences the pain when she is walking and breathing, during which time, it is possible to hear the sound of typing alongside minimal responses 'okay' and 'yeah'.

Extract 3 [20:10-22:24]

- 1    *PhP: we will do the test again (.) to see if it makes any difference*
- 2    *(.) now:- (.) what I've noticed I just want to ask you another couple of*
- 3    *questions now okay*
- 4    *Pt: mm*
- 5    *((PhP reads five sentences for the patient to select from, and then*  
*discuss the patient's selection))*
- 6    *PhP: you said there's pain in your chest yeah*
- 7    *Pt: mm:*
- 8    *PhP: can you describe the pain to me please (.) so where are you*  
*getting the pain like when I'm walking*
- 9    *((PhP clicks mouse))*
- 10   *PhP: okay ((starts typing))*
- 11   *Pt: walking*
- 12   *PhP: yeah ((typing))*
- 13   *Pt: an breathing*
- 14   *(.)*
- 15   *Pt: I feel heaviness:*
- 16   *PhP: okay ((typing))*
- 17   *PhP: a:nd*
- 18   *((typing))*
- 19   *PhP: an:d u:hm ((typing))*

- 20 Pt: *(then I don't feel so mostly) (.) like nu[mb*  
21 PhP: *[so is it (.) is it*  
22 *all over your chest*  
23 Pt: *all of my chest gets tight when I'm walking*  
24 PhP: *but- when (.) when I said tight and pain different thing*  
25 Pt: *mm[m*  
26 PhP: *[pain is when you get p[ain*  
27 Pt: *[pain*  
28 *(0.4)*  
29 Pt: *I have pains*  
30 PhP: *you have pains here*

The patient subsequently talks about how she experiences the breathing difficulties during which time there is (again) the sound of typing. The patient reiterates that she feels a 'heaviness' (line 15) and then explains that she feels a numbness in her chest '*then I don't feel so mostly) (.) like nu[mb*' (line 20) and again reiterates that she feels pain when she's walking. When the patient communicates how her condition is impacting on her and how she experiences the condition, the pharmacist's responses appear more clinically orientated. The sound of typing suggest that she is focused on entering information in the patient's medical notes and is possibly distracted and perhaps less attentive to the what the patient is saying.

While recognising the importance of obtaining clinical information, the structured consultation appears to not only foreclose opportunities for the patient to communicate but also forecloses opportunities for the pharmacist to offer positive emotional labour. This pharmacist, for instance, does not tend to deviate from her agenda and does not therefore improvise and respond to the patient empathically by acknowledging and communicating understanding of the patient's experiences of living with a chronic respiratory problem.

This structured, agenda driven style of consultation is indicative of this pharmacist's style and appears to foreclose opportunities for the patient to disclose or communicate her concerns unless explicitly invited to do so. When the patient does communicate emotional cues and concerns, there is little

evidence of positive emotional labour in which the pharmacist improvises and goes off script to develop relational depth nor communicate to the patient that she has understood the patient and her experience of living with a chronic health condition.

*From the diary: reflections on consultation 358*

This consultation lacked the relational depth, warmth and empathy observed in other consultations – it felt slightly dispassionate as if the patient was not being seen as a human being but rather as an object to be processed – I admit that that sounds very critical. The consultation sounded very formulaic and structured that the patient had little opportunity participate. In some instances the patient did communicate how their condition (COPD) was impacting on them and what it was like to experience breathlessness – however the pharmacist appeared to be so focused on her set of questions that perhaps she did not truly hear the patient. At times, it was frustrating listening to this consultation as it appeared so far removed from the approaches idealised within patient centred care.

**Case B - Pharmacist Prescriber Patient 1050**

Similarly in this medication review with a different pharmacist prescriber, the consultation is very structured using a checklist of questions to enable the pharmacist to complete a computer template – the sound of typing is heard frequently. This excerpt typifies this pharmacist's consultation style which employs a series of predominantly closed questions where there is little space or opportunity for the patient to communicate any additional information beyond what is being elicited. There is little evidence of the pharmacist seeking to elaborate on the information provided by the patient which reduces opportunities for the pharmacist to learn more about the patient's health, illness or treatment experience. For example, in line 6, the pharmacist asks the patient a closed question about the frequency with which the patient takes their painkiller: *'uhm: (-) .ts do you take those painkillers regular<sup>ly</sup>'* to which the patient replies *by saying 'wha- yes hh'*. However, the pharmacist assumes that the patient has mutual understanding of the term 'regular' which could be open to

interpretation. Furthermore, and of clinical relevance, the pharmacist does not explore whether the painkillers are effective in managing the patient's pain levels. This style of medication review is reductive and narrows opportunities for a more useful and meaningful consultation which involves the patient and explores their experiences of taking prescribed medication and its perceived effectiveness.

At this extract highlights, the consequences of running to script can have the, albeit unintentional, effect of foreclosing opportunities for patients to express cues and concerns which have the potential to yield important biopsychosocial information.

### **Pharmacist Prescriber Patient 1050**

#### Extract 1[13:27]

- 1 PhP: *a:nd you take something for your cholesterol,*
- 2 Pt: *yeah three: three tablets [(.) °three tablets°*
- 3 PhP: *[that's right yeh yeh .hh >uhm and you've< got*
- 4 *some painkillers*
- 5 *(-)*
- 6 PhP: *uhm: (-) .ts do you take those painkillers regular↑ly*
- 7 Pt: *wha- yes hh*
- 8 PhP: *painkiller*
- 9 Pt: *that (killer) (-) yes I have for the back, hh*
- 10 PhP: *okay,*
- 11 Pt: *so: much problem and they: d- [(I take the one)*
- 12 *paracetamol yuh*
- 13 PhP: *[so do you take it every day*
- 14 PhP: *every day*
- 15 Pt: *yuh every day*
- 16 PhP: *okay, (-) uh:m (-) .ts and then you take the medicine for your*
- 17 *diabetes*
- 18 ....
- 19 PhP: *so: I think medicines wise you're fine*

### **Case C– GP and Patient 63**

In this final consultation, a female patient has been invited in by her GP to discuss the results of her cholesterol test. During the consultation, it also emerges that the patient is being managed by the same GP for on-going health conditions which include chronic arthritis and a foot ulcer which the patient attributes to the side effects of her medication for her arthritis. During the consultation, the conversation soon switches to a discussion about the patient's alcohol consumption as a possible contributing factor for her higher cholesterol. During this conversation, it becomes evident that the patient is aware of and has been trying to reduce her consumption of alcohol and cigarettes; a topic which appears to have been discussed in previous consultations.

During the consultation, the patient communicates several cues and concerns relating to the underlying psychosocial reasons underlying her '*bouts*' of drinking as she describes them, and her smoking, both of which are triggered when she feels '*depressed*' or when she gets '*worked up*'. The patient communicates that she drinks alcohol when she feels depressed or when she gets '*worked up about things*' but is also aware that alcohol is a depressant when she says '*I know that drinking depresses you anyway*'. The patient then reiterates that she gets '*worked up*' and '*upset*'. Despite reiterating similar cues, the GP does not respond to or follow up the patient's cues and concerns underpinning her drinking behaviour.

### **GP Patient 63**

#### Extract 1

[04:01]

- 1        *Dr: a box is: quite a lot then isn't it*
- 2        *Pt: yeh*
- 3        *Dr: [*

4 Pt: [so I also I do have bo:uts, I have like-  
5 (-)  
6 Pt: I get myself worked up  
7 Dr: right  
8 Pt: and when I get myself worked up I- ( )- cos I know in me  
9 own head, (.) that ( ) if I get depressed I drink (.) I know that  
10 drinking depresses you anyway but it's just ((clicks fingers)) there (-)  
11 and I get worked up about things, and get upset, and my foot at the  
12 moment has been  
13 Dr: [( )  
14 really (.) peeing me off pardon me but-  
15 Dr: we'll have a look at the foot now but (.) uh:m  
16 (-)  
17 Pt: it kicked off terrible last night  
18 (-)  
19 Dr: I still haven't got an amount for how much you drink I'm sorry  
20 (-)  
21 Dr: if ( )  
22 Pt: Oh (.) sorry I didn't mean to (.) [(go in)  
23 Dr: [let's just narrow it down that's all  
24 Pt: too much (.) can't you just put too much  
25 Dr: heh heh heh  
26 Pt: heh heh heh  
27 Dr: give me an idea of how many glasses of wine you drink a day then  
28 how would  
29 that- (.) how would that be how would that work  
30 Pt: o:h god  
31 (.)  
32 Pt: seven or eight glasses a day it's gotta be  
33 Dr: okay

The patient then switches topic to talk about her foot to which the doctor responds with a holding statement while he pursues a quantity for how much she drinks 'we'll have a look at that foot now but uhm..... I still haven't got an amount for how much you drink I'm sorry'. When he says 'I still haven't got an amount for how much you drink' (lines 15-19), the patient responds by

apologising in line 22 *'Pt: Oh (.) sorry I didn't mean to (.) [(go in)]'*. The doctor subsequently responds to the patient by asking her to quantify how much she drinks: *' [let's just narrow it down that's all'* (line 23) after which the doctor elaborates his request by asking *'give me an idea of how many glasses of wine you drink a day'* (27-29).

In extract 2, later on in the consultation, the patient says that *'but no I do think like that and then my partner thinks I'm really (cookoo)'* to which the doctor responds by asking her if her partner drinks. The patient then utters another potential cue to explain her underlying drinking when she says in line 7: *'well, I'm on my own a lot of the time'* as it emerges that her partner works during the evenings. The doctor does not explore the possible psychosocial cues which could explain some of the reasons underlying her drinking behaviour but appears focused ascertaining how many units of alcohol she consumes.

During this consultation, the doctor asks the patient seven times to quantify how much she drinks during which time the patient conveys important social and emotional cues and concerns about her inner psychosocial world which may belie her drinking. The GP's orientation towards ascertaining information about how much she drinks may foreclose opportunities to offer positive emotional labour – to explore the patient's cues and concerns and understand more about the reasons for her drinking bouts. This consultation appears to be driven more by the GP's agenda and need to complete a template or QOF box rather than responding to and incorporating the patient's psychosocial needs during the consultation.

#### *Extract 2 [07:43]*

- 1 Pt: but no I do think like that and then my partner thinks I'm really
- 2 going (cuckoo)
- 3 Dr: does your partner drink
- 4 Pt: not a lot. No he don't- (.) not a lot
- 5 Pt: ( )
- 6 Dr: so do you drink on your own a lot then

7 Pt: *well I'm in on me own most of the time*  
 8 (-)  
 9 Pt: *so (-) you know I do try to find things to keep myself busy, I- I do*  
 10 *tapestry*  
 11 Dr:  
 12 Pt: *sounds pathetic but I do tapestry .hhh and when I'm doing tapestry*  
 13 Dr: *[(get yourself a drink I sponse)*  
 14 Pt: *I know but when I'm doing tapestry when I'm doing tapestry it kills*  
 15 *two*

This consultation also raises the concern about health surveillance and its effect on the patient. By gathering information about how much the patient drinks, and focusing on alcohol consumption, the GP does not explore the patient's psychosocial reasons underlying her reasons for drinking alcohol. As has been highlighted by previous authors, this focus on the individual's lifestyle choices can potentially problematise or pathologise the behaviour of the individual without addressing or exploring the possible psychosocial reasons underlying her lifestyle decisions (Antonovsky, 1996).

From the diary: reflections on consultation 63

In the opening of the consultation, the GP and patient engage in considerable banter – the patient jokes that she's luck to be there as her lift had let her down. The patient employs this light heartedness throughout the consultation, including moments in the consultation when the GP is engaging her in more serious conversations when gathering information about how much she drinks. I wondered to what extent, the patient's use of humour is a defence against having to engage in more serious discussion about her high cholesterol and alcohol use. It appears that the patient has a lot going on. She has a leg ulcer which she is being treated for and has high cholesterol. Amidst the lightness and humour, I hear the patient communicating important cues which provide a glimpse into her psychosocial world, such as her admission that her partner thinks she's 'cuckoo'; cues about being depressed when she says that she drinks when she's depressed and that she knows that drink depresses you. She admits



to getting worked up about things and getting upset – this are profound insights into this patient's inner world which, I feel, are being side-stepped by her GP. When listening to this consultation, I felt that the doctor's pursuit of how much she drank detracted from addressing the elephant in the room – the possibility that the patient was depressed and was perhaps using alcohol as a way of managing her emotional world. On listening to this consultation repeatedly on different occasions, I was left feeling slightly saddened as I felt the fundamental needs of the patients were not being met.

It would appear that these style of consultations are driven primarily by the professional's agenda which may reflect organisational or process demands of QOF for which practices receive a financial incentive from the NHS. To meet the requirements of QOF, practices are financially rewarded if they undertake regular medication reviews, blood pressure checks and relevant clinical tests for patients diagnosed with a long-term health conditions (such as diabetes, hypertension or asthma). To be reimbursed, practices are audited to ensure relevant information has been collected and recorded subsequent to relevant reviews and tests being conducted with patients (NHS, 2013). However, recent ethical concerns have been raised over whether the reductionist and process demands of QOF are detracting or preventing health care professionals from delivering a more humane and patient centred approach to the healthcare encounter (Gillam, 2013).

Perhaps in this way, the process demands of QOF and similar organisational structures represent the wider institutional or political demands placed on workers which prevent or reduce opportunities for the employment of emotional labour in healthcare encounters. One of the central tenets of Hochschild's theory on emotional labour was the recognition of how workers' feelings can become commodified within an organisational setting. Hochschild observed that workers would be expected to perform or behave, including their feelings towards customers such as needing to smile, suppress feelings or run to script typified by the 'have a nice day' offering within a service sector encounter, for example.

Within a healthcare setting, it has been argued that workers such as healthcare staff in hospitals, are afforded greater autonomy in the way their emotions are managed or owned (Bolton, 2000). In the context of general practice, although

GPs, nurses and pharmacists may also be afforded a similar or perhaps greater degree of autonomy, it could also be argued that the demands of QOF or other structured approaches to managing chronic disease may influence the extent to which professionals are able to offer emotional labour. It could be that the demands of QOF, for instance, reduce opportunities for the healthcare professional to offer a person-centred consultation since the process demands of QOF become the principal driver of the consultation. Consequently, opportunities to improvise and go 'off-script', having time and space to talk, listen, engage and invest in the therapeutic relationship are reduced while tasks and templates are completed. Consequently, as it has been argued, the process demands of QOF could, albeit inadvertently, reduce opportunities to offer a more humane and patient centred consultation (Gillam, 2013).

The structured and formulaic nature typified by the consultations presented previously, may also reflect the process of managing patients with chronic diseases. This approach has recently been described as the 'McDonaldisation' of general practice in reference to the way patients are 'processed' in the way that they are passed down a production line of workers who manage their care in turn – the doctor diagnoses and the responsibility for managing chronic condition such as diabetes is often handed over to nurses and, more recently, pharmacists, in some practices. It could be argued that medication reviews or chronic disease reviews (such as asthma, diabetes or hypertension) are part and parcel of this process and that meeting the demands of QOF could also lead to the objectification of patients who may come to be regarded as a set of symptoms with various biomedical indicators/markers which need to be managed rather than patients viewed as individuals with feelings who might prefer and benefit from being offered a more personalised and patient centred consultation (Gillam & Siriwardena, 2011).

Consequently, rather than owning healthcare workers feelings, as Hochschild posited, it could be argued that within the context of primary care, the wider institutional and political demands constituted out with the immediate organisational setting of general practice are preventing or steering healthcare workers away from working within a patient centred framework. Patient centred care and perhaps the patient-professional relationship may be compromised when healthcare workers are employed to meet the demands of QOF, which

orientate the consultation along biomedical lines and reduce patient's health and illness experience into patient outcomes which are quantifiable into measurable units (such as blood pressure, cholesterol, Body Mass Index, or units of alcohol consumed). This reductive approach to the consultation in which information about the patient's health and illness experience is elicited and processed into quantifiable units of information potentially run the risk of dehumanising patients while obfuscating some of the more complex psychosocial concerns relating to people's health and illness experience.

Examples of this are reflected in the doctor who repeatedly asks his patient to quantify how much alcohol she consumes without exploring her cues which confer information about her psychosocial world and potential reasons explaining her consumption of alcohol; or in the pharmacist who begins her consultation with enquiries about the smoking habits of a patient who has suspected COPD without exploring the patient's iterated concerns about the impact of her condition on her day-to-day life; and in the nurse who asks an elderly patient if she smokes in response to the patient's concern about having had swine flu. It is possible to see how these more mechanistic and agenda driven consultation styles compromise the ethos of patient centred care by preventing patients from participating and preventing the professional from understanding more about the patient and offering a more therapeutic response. Furthermore, in focusing on measurable biomedical indicators, it may jeopardise the very heart of any healthcare encounter – the patient-professional relationship.

Furthermore, the findings suggest that structured and task-driven consultation styles can reduce patients' opportunities to participate in the consultation and communicate their concerns. Moreover, emotional disengagement and lack of exploration of patient's cues and concerns, may also inhibit patients' expression of their concerns. Previous evidence suggests that patients communicate less cues and concerns when professionals do not actively invite or explore patients' psychosocial concerns (Bensing et al., 2010). Furthermore, previous research also indicates that when patients do not disclose their concerns, there is greater potential for misunderstandings, non-adherence, incomplete diagnosis and patient dissatisfaction (Britten et al., 2000; Roter and Hall, 2006).

In previous research, it was found that consultation length was positively associated with a better recognition and exploration of patients' psychosocial

problems. This study found that patients and GPs discussed fewer psychosocial problems and more likely to be prescribed antibiotics when consultations were conducted in under six minutes (Howie et al., 1991). However, phase one of this study did not find a positive correlation between the numbers of cues and concerns expressed in consultations despite evidence that pharmacists had significantly longer consultations compared with those consultations with nurses and doctors (pharmacists=18.2 mins; nurses=11.2 mins and GPs=10.1 mins). Additionally, the phase one findings did not find significant differences between the number of cues and concerns expressed per prescriber group.

However, in spite of these phase one results, the findings from the qualitative phase, namely structured driven consultations, have identified that this style of consultation can preclude patients from participating in the consultation and can narrow opportunities to express cues and concerns. This lack of opportunity may explain why patients of some pharmacists expressed fewer cues and concerns (3.4 c/c), on average, compared to GP consultations (3.7 c/c), although these differences were not significant. It can be noted that individual differences within prescriber groups accounted for a greater (15%) variation in the frequency of cues and concerns expressed as compared to differences between prescribing groups. This phase one finding may therefore relate to the findings identified in phase two; namely that a professional's consultation style can create or hamper opportunities for patients to participate in and communicate during the consultation process.

The influence and effect of consultation has been a cause for great debate in general practice literature (cf Ogden et al., 2009; Howie et al., 1991). Evidence suggests that the association between consultation length and patient satisfaction may be more nuanced than merely attributing patient outcomes (i.e. satisfaction) to consultation length. For instance, Ogden et al. (2009) suggest that patient satisfaction is influenced more by how doctors use their time with patients rather than the length of the consultation - patients value empathetic professionals and therefore patients feel more satisfied when doctors listen and take the time to understand them (Ogden et al., 2004).

Moreover, consultation length has been found to vary depending on the patients' underlying reasons for consulting; consultations which involve discussions of mental health or psychosocial problems, take longer (Zantinge et al., 2005). As

a result, when considering the impact of consultation length on the way in which professionals respond to patients' cues and concerns, the case mix of professionals and patients' reasons for consulting can potentially influence the length of the consultation. As this chapter has highlighted the influences on patients' opportunities to participate and express their cues and concerns and professionals' response to them may be influenced by a range of factors, consultation length representing one of a range of potential reasons.

### **5.3 Discussion**

This chapter has presented and discussed both the facilitators and barriers to employing positive emotional labour in response to patient's emotional cues and concerns. Section one presented and discussed the range of facilitators to employing positive emotional labour employed within the healthcare encounter. The findings highlight the importance of being able to adapt to the needs of individual patients as demonstrated in professionals who demonstrated a flexibility in their approach to the consultation. This was particularly evident when attending to patients' concerns, when communicating empathy and in integrating patients' biopsychosocial needs within the consultation process. This flexibility conveys an ability to improvise and equates to a more person centred responsiveness whereby it is evident that the professional has shifted their attention and discourse beyond the clinical demands of the consultation. These consultations are not explicitly driven by the professional's agenda and are typified by consultation styles which are more attuned to the patient's biopsychosocial world. The range of facilitators highlight that positive emotional labour is more than the response alone; it equates to the professional creating space in the consultation, listening and communicating understanding to the patient. It involves an ability to attune to the world of the patient while also carrying out clinical duties and other demands required in the consultation process (making notes and printing prescriptions, attending to clinical tasks or completing QOF related data).

Moreover, these healthcare professionals demonstrate that they build rapport with their patients, engage in side conversations and show evidence of

connecting with their patients through humour and empathy. These consultation skills reflect current consultation models as found in Neighbour's (2004) consultation model and the Calgary Cambridge guide, for example. Such models advocate the use of rapport during the opening of the consultation, exploring and accepting patient's views/feelings, and the employment of empathy and support throughout the consultation process (Kurtz et al., 2003).

Section two discussed the key barriers to offering positive emotional labour within healthcare encounters between patients, GPs, nurses and pharmacists. When healthcare professionals keep it clinical and maintain the consultation along biomedical lines, it leads to a disengagement with patients' emotionality within the consultation. By 'keeping it clinical' patients may be denied the therapeutic and clinical benefits of positive emotional labour – talking and being heard. Although emotional disengagement was evidenced across the three professional groups, it was more notably found in consultations with GPs. This observation is supported by phase one findings which found that GPs are significantly more likely to miss patients' cues and concerns, mainly through redirecting the consultation along biomedical lines, when compared to nurses and pharmacists.

The findings also indicate that when healthcare professionals are task oriented, they often ignore or overlook patient's iterated cues and concerns. Additionally, when attending to tasks, health care professionals may foreclose opportunities for patients to participate because the professional is pre-occupied with their task. As has been previously highlighted, task oriented consultations also foreclose opportunities for rapport building by engaging in side conversations (Jones and Collins, 2007) which also enable the patient provide information which may relate to their biopsychosocial world. Additionally, as Menzies Lyth (1988) observed, task-oriented nursing can also act as a defence against anxiety as being occupied by a task enables the nurse to emotionally distance themselves from their patients and from emotionally demanding situations (Menzies Lyth, 1988).

Furthermore, the consequences of running to a structured or agenda driven consultation have been discussed. Structured, process and agenda driven

consultations are often typified by consultation styles in which the professional is less likely to adopt a more flexible approach to the consultation and to the needs of patients which include picking up and responding empathically to their cues and concerns. These examples of structured and agenda driven consultation styles can have the effect of foreclosing opportunities for patients to express cues and concerns and which therefore remain unacknowledged, unexplored and unmet. These consultation styles may have precluded patients from participating and distracted or prevented professionals from working and responding within a patient centred framework. Previous research suggests that when patients are unable to voice their ideas, concerns, expectations and preferences for treatment, for example, it can have negative clinical and psychotherapeutic outcomes for patients. In the context of decision making about treatment or in medication reviews, for instance, it is important to enable patients to voice their thoughts and feelings. When patients are unable to do this, they are often less satisfied with the consultation and are less likely to adhere to their treatment (Stevenson et al., 2004). Moreover, given patients' resistance (reluctance) to medicines (Pound et al., 2005), it raises the importance of engaging with patients within a patient centred framework which incorporates a shared decision making process with regards to treatment. Another potential challenge or barrier to delivering positive emotional labour within a patient/person centred framework may be attributed to the process demands of professionals to maintain and update patients' clinical data. For instance, the structured styles of consultation we saw in section three may be influenced by practice demands to collect data for the Quality Outcomes Framework (QOF). Criticism has been directed at QOF since it has led to changes in the way patients with chronic diseases are managed with an approach being underpinned by the biomedical model due to pay-for-performance directives which require the supply of clinical indicators and measurements (Chew-Graham et al., 2013; Mangin and Troop, 2007).

However, the QOF cannot account for the structured nature of all consultations because it does not explain why some professionals are able to withstand the potential constraints of QOF and offer a more integrated consultation. The variation of consultation styles and barriers to delivering emotional labour is likely to be accounted for by a range of factors which will be discussed further in the concluding chapter - Chapter 6.

To date, the literature on emotional labour within a healthcare context has predominantly focused its attention on nurses in secondary care. One principal theme to emerge from this body of literature is the gendered nature of emotional labour - the ways in which female nurses are socialised and expected to carry out emotional labour. In this study, with the exception of nurses who were all female, emotional labour appeared to bridge the gender divide of male and female pharmacists in this study. Likewise, the absence of emotional labour or barriers to emotional labour was evident across both male and female professionals. However, one difference in terms of the gendered aspect of emotional labour relate to the phase one finding which suggests that male GPs were less likely to respond positively to a patient's cue or concern. These findings are echoed by the findings from the qualitative analysis and may reflect the gendered and professionalised nature of emotional labour (Smith, 2012; Theodosius, 2008; Fineman, 2003).

The breadth and depth of emotional labour employed across the professional groups has been made visible through the findings of this research while some of the challenges or barriers to employing emotional labour were evident in structured or agenda driven consultations which reduced opportunities for patients to participate. In these consultations, the work and investment evident in positive emotional labour was reduced by some professionals who did not engage or respond on an emotional level while barriers to patient centred approaches reduced patient participation and patients' involvement.

These findings reflect the importance of communication skills training across the professional groups and recognition that emotional labour can no longer be an 'expected' part of a healthcare professional's work. Therefore, it is imperative to recognise and value the range of skills, approaches and attributes required when employing emotional labour within a healthcare context. Professionals need to be equipped with the necessary skills, approaches and attitude while the value of emotional labour needs to permeate the ethos of all individuals in training and that it is subsequently reinforced in practice. The findings also perhaps highlight the need for reflective practice and value of adopting an inter-disciplinary learning approach to patient centredness and employment of emotional labour—so that that doctors can learn from both nurses and pharmacists and vice versa. In training and in practice, the importance of working within a patient centred



framework needs to be emphasised, reiterated and reinforced intra and inter professionally.

The findings emphasise the significance of the patient-professional relationship and the work involved in emotional labour to develop and maintain a therapeutic and trusting relationship. The findings highlight that both the needs of patients and their relationship with their healthcare professional may be compromised when the consultation is driven to meet professional and organisational demands. In those consultations where healthcare professionals managed to meet, integrate and respond to the wider, more holistic needs of patients, the professional employed a range of skills, approaches and attributes which communicated caring and understanding to health care without negating or overlooking the wider demands of their role. These findings have been made visible through the analysis of a sub-sample of transcripts of professional-patient interactions. It is hoped that in identifying the range of skills and approaches employed in emotional labour by GPs, nurses and pharmacists, the work of these professionals are made more visible and valued.

The study has highlighted the challenges and complexity of employing positive emotional labour, particularly when accommodating and integrating patients' biopsychosocial needs within a time-limited consultation. It is therefore unsurprising that healthcare professionals may not always work within a patient centred approach and that sometimes the work may be demanding and challenging. The findings highlight the realities of providing a patient centred approach or offering positive emotional labour in practice and that these approaches are open to a myriad of influences and constraints at both micro (patient-professional interaction) and macro level (socio-cultural feeling rules within the workplace and process demands).

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# Chapter 6: Reflections

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*Chapter 6* first takes a personal perspective to reflect on the emotion work/emotional labour involved in various aspects of the research process, including the labour employed in collecting data and in data analysis. The following section will consider and reflect upon the study aims and research questions in turn. The first section summarises the findings from phase one and two to understand how healthcare professionals manage patients’ cues and concerns. This section summarises the influence of sociological factors (gender and age of professional) and context (process demands on the consultation) on the way emotionality is managed within the consultation process. The next section reflects on the socio-cultural influences on the management of emotionality while the subsequent section reflects on the implications of the



study findings on the training and support needs of healthcare professionals. The next section provides an overview of the study methodology, in particular the advantages of employing a mixed-method approach and some of the limitations in doing so. In particular, this section discusses some of the epistemological challenges of researching emotions and empathy during the course of this study. These sections principally address the limitations identified in the data collection, coding and analytic stages of the study. The following section offers suggestions for future research while the final section considers the contributions and originality of this work.

## **6.0 Reflections on the Emotion Work of a Researcher**

*'Emotionality lies at the intersection of the person and society, for all persons are joined to their societies through the self-feelings and emotions they feel and experience on a daily basis. This is the reason the study of emotionality must occupy a central place in all the human disciplines, for to be human is to be emotional' (Denzin, 1984: vi).*

To be a researcher is to be emotional too and given the use of emotion work theory within this study, I thought it would both appropriate and poignant to reflect on the emotions experienced and emotion work undertaken by me on my research journey. I will also reflect on what I have learnt from this and suggestions for supporting researchers who may also undertake emotion work during the course of their work.

For researchers who work in sensitive research areas and/or within social and health care research, the experience can often be moving, meaningful, interesting and profound since one is allowed privileged access into the lives and experiences of wide ranging individuals. This would equally apply to the journey that I have undertaken throughout this study; it has been a privilege to listen to the breadth and depth of consultations between professionals and patients. The journey has also been an emotional one, at times, and I would agree with Dickson-Swift et al. (2009) who acknowledge that the research process can be emotionally demanding. Whilst carrying out the field work for this study, in analysing the data and in the process of writing up, I would describe some of my experiences as demanding, stressful and emotive. During the course of writing

up, I was employed as a researcher on a different project and so the demands on my time were greater and considerably more stressful. Doctoral research is after all a labour of love, it is physically, intellectually and emotionally demanding! I therefore wish to describe the type of emotion work involved in aspects of the research process and to highlight and reflect upon what has been involved in terms of emotion work and to identify the type of support needs that social science researchers may benefit from.

### **6.0.1 Emotion Work and Data Collection**

As with most social science research involving human beings, a considerable amount of performance was required when working in the field when collecting data in GP practices. For instance, there was considerable emotion work involved in the performative requirements of developing rapport with professionals and patients or when liaising with healthcare professionals, practice managers and reception staff. Emotion work was also involved when adapting to each practice culture, as an outsider, which could be daunting, stressful and demanding. There was emotion work involved in liaising with different practice staff in order to facilitate the process of recruitment – at times the work could be particularly challenging when requests were not communicated.

The recruitment of patients to the study necessitated being in situ in the waiting room of the surgery. When working in the waiting room, patients whom I approached were sometimes unclear about what my role or professional badge was and sometimes I felt daunted and self-conscious by my visibility, particularly in a busy waiting area or in the act of introducing myself and research within earshot of others. At times, I felt very much 'on-stage' and consequently outside my comfort zone and which required me to perform to present a convincing self-image in order to hide my fears and anxieties.

In a separate issue, I had to manage my concerns and feelings related to having to work in such an unhealthy environment, particularly mid-winter, when waiting

rooms were full with patients spluttering and sharing their seasonal colds and coughs with anyone in relative proximity. Whilst undertaking field work at these times, I was more susceptible to picking up illnesses and therefore had to balance the competing demands of my work with the need to be well – a challenging feat given the nature and location of the work! I managed feelings of resentment and frustration about having to work in an environment that exposed me to infections. Additionally, I often felt 'low' when physically ill because I am a very active person and therefore find inactivity and inertia a challenge. Exposure to waiting room contagions is certainly not written into any ethic's application in terms of potential harm to researchers! However, being unwell perhaps gave me greater empathy with patients who were going through similar experiences.

### **6.0.2 Emotion Work and Data Analysis**

There was considerable emotion work involved in listening to over 300 consultations, covering wide ranging health conditions, often listening to each recording three or more times. Sometimes listening to consultations, particularly those which involved sensitive or emotive topics was often emotionally exhausting. Listening to the breadth of consultations could evoke a range of feelings ranging from joy, frustration, sadness to anger. I often felt moved and emotional when listening to some consultations; some consultations were 'heart-breaking'. In the process of listening to patients in the waiting room and on tape required empathy and good listening skills which also constitutes emotion work. Some consultations made me feel angry in instances when I felt the healthcare professionals did not appear to be listening or when their response sounded discordant – out of tune with the emotional tone of patients' concerns.

### **6.0.3 Supporting Researchers in Their Emotion Work Role**

Given the emotion work required of researchers in this field, I feel that researchers need to have the appropriate support in place to enable them to manage their emotionally demanding roles and feel supported. I have worked as a researcher since 2003 and have often felt that the emotion work of researchers is overlooked and under-acknowledged. Perhaps the emotion work is seen as part and parcel of the job but it is not consistently recognised or perhaps valued to the extent it could be. Additionally, perhaps because the emotion work of researchers is not fully recognised, the available support from line managers, supervisors or colleagues often occurs on an ad hoc basis. I have often been perplexed that while research ethics committees serve to protect the needs and rights of patients and professionals to ensure an ethic of care is embedded and enacted in the research process a similar ethic of care is not always afforded to researchers to the same extent. While the National Research Ethics Service (NRES) guidance does offer some protection for researchers, this does not always extend to practice in terms of structured support.

In the course of this study, I was fortunate in the sense that I worked with a supportive manager and colleague on the same study. In particular, my colleague and I both made time and space to discuss some of our experiences in the field and the emotional impact of listening to some consultations. From previous experience, I recognise that researchers gain a considerable amount of peer support from their fellow researchers. However, the onus is on the researcher to actively seek out support and consequently the availability and quality of support often falls to the hand of serendipity rather than something that is explicitly built into the framework of a project. I feel that recognising the emotion work demands and making them explicit within a research project will encourage managers, supervisors and institutions to offer the type of regular and emotional support that may be needed. This point is echoed by a number of authors (Darra, 2008; Harris and Huntington, 2001, Hubbard et al., 2001) who call for the feelings of researchers and participants to be considered when designing research. Darra (2008) recommends that regular supervision would need to incorporate support to manage the emotional demands and emotion work involved in the work of a researcher. I also feel that a similar ethic of care

needs to be extended to researchers in addition to their participants throughout the research process. I have found emotion work theory useful in terms of explicating the emotionality involved in undertaking doctoral research.

The followings sections will address the research questions posed at the outset of this study.

## **6.1 Addressing the Research Questions**

1. How do GPs, nurse and pharmacist prescribers manage patients' emotional cues and concerns in healthcare encounters in primary care?
2. How do sociological factors (such as gender, age of professional, prescriber training) and context (such as wider political context, for example, process demands such as QOF or changing roles and responsibilities within the primary care workforce) influence the ways in which professionals manage patients' cues and concerns?
3. What are the implications of the findings in terms of identifying future support and training needs of healthcare professionals?
4. How do the methods employed in phase one and two compare in exploring this topic area?

The following sections will address each of these research questions in turn.

### **6.1.1 How do GPs, nurse and pharmacist prescribers manage patients' emotional cues and concerns in healthcare encounters in primary care?**

The advantage of using a mixed method approach was to enable different perspectives to be taken of the study phenomena by employing different research questions and different approaches to analysing the data. Phase one enabled conclusions to be drawn about types of responses to patients' cues and concerns as expressed by GPs, nurse and pharmacist prescribers. Phase two looked at the ways in which professionals managed patients' emotional cues and concerns throughout the consultation process. While phase one and two

adopted different angles in its view of the study phenomena, the results of phase one complemented the findings of phase two and vice versa, in the following respects. Both phases provided an overarching view of emotion management undertaken by GPs, nurse and pharmacist prescribers, as will be discussed below.

The findings from phase one indicate that pharmacists and nurses responded more positively to patients' cues and concerns compared to GPs. These findings suggest that pharmacists and nurses are more likely to acknowledge, clarify, or pursue patient's emotional cues and concerns compared to GPs in this study. Conversely, GPs were more likely to inadequately acknowledge, redirect along biomedical lines or interrupt patients' cues and concerns when compared with nurses and pharmacists.

Notably, the employment of positive emotional labour or barriers to it varied within and across the professional groups. For instance, there were examples of professionals who are more adept at integrating the patient's agenda, their emotional cues and concerns within the consultation process which contrasts with those professionals who employed a more structured, formulaic style of consultation which reduced space and opportunities for patients to talk and for professionals to listen and communicate understanding.

The findings provide evidence of the barriers and facilitators to participation in the consultation and thereby highlight the importance of enabling patients to voice their concerns during the consultation process. Previous research suggests that when patients are unable to voice their ideas, concerns, expectations and preferences for treatment, for example, it can impact on the clinical and psychotherapeutic outcomes for patients (Zimmerman et al., 2007; Oz, 2001; Levinson et al., 2000; Elwyn & Gwyn, 1999). Moreover, in the context of decision making about treatment, in medication reviews, for instance, it is important to enable patients to voice their thoughts and feelings. When patients are unable to this, they are often less satisfied with the consultation and are less likely to adhere to their treatment (Stevenson et al., 2004). Additionally, given patients' resistance (reluctance) to medication (Pound et al., 2005), it emphasises the importance of engaging with patients within a patient-centred framework which incorporates a shared decision making process with regards to

treatment. By actively involving patients in this process, treatment outcomes are more likely to reflect patients' preferences. Therefore, structured or agenda driven consultations, for instance, which can preclude patients from participating or voicing their concerns may have implications for the way in which patients' biopsychosocial needs are met, including patients' preferences for treatment or concerns about them.

Phase one also made visible the ways in which professionals missed patients' cues and concerns, focusing on professionals' responses. The second phase viewed the barriers to employing positive emotional labour throughout the consultation while also considering the influence of process demands. This will be discussed later on in this chapter.

Phase one identified the ways in which professionals 'miss' patients' cues and concerns through inadequate acknowledgment, redirecting along biomedical lines or by interrupting. Phase two also identified a range of ways in which professionals did not provide space in the consultation or directly disengage with patients' emotionality in the healthcare encounter. The range of facilitators of positive emotional labour employed by some professionals served to highlight other consultations in which these facilitators were absent.

The findings from both phases have highlighted differences and similarities to the management of patients' emotionality across the three professional groups. Phase one provided a snap-shot of professionals' responses to patient's cues and concerns whilst phase two elaborated on the process of emotional labour including the range of facilitators and their influence on how patients' emotionality is managed within the healthcare encounter.

### **6.1.2 How do sociological factors and context influence the ways in which professionals manage patients' cues and concerns?**

#### **6.1.2.1 Gender of Prescriber**

Phase one identified that male GPs were significantly more likely to miss patients' cues and concerns compared with female GPs, a finding supported by

previous research which suggests that female doctors are more empathic or patient centred (Bertakis et al., 2009; Bylund & Makoul, 2002; Roter et al., 2002). Similarly, phase two findings reflect how male GPs emotionally disengaged with patients' emotionality by maintaining the consultation along biomedical lines. These findings may highlight the gendered nature of emotional labour which may be explained by socio-cultural influences on the feminisation of emotion work as highlighted by previous authors (Gray and Smith, 2009). However, any conclusions regarding the gendered aspects of emotion work need to be taken cautiously due to the small sample size of professionals in this study.

The General Medical Council (2012) predicts that in the next decade, the proportion of female GPs is likely to achieve parity with male GPs in general practice. With the addition of a range of prescribers in primary care, many of whom are female (for example, nurse prescribers), it will therefore be useful to consider how or if gender will play an influential role in how these professional groups manage patients' emotionality during healthcare encounters. Based on previous evidence suggesting that female GPs tend to be more empathic, the increasing feminisation of general practice may result in better emotion management. Unfortunately due to the small number of pharmacists in this study (N=12), reliable conclusions about the gendered nature of emotion work in pharmacists was not feasible to make. In this study, all 19 nurses were female and so comparisons cannot be made with male counterparts. However, what is interesting to note is that regardless of gender (as all nurses were female), there was still some variation in the way nurses managed patients' emotional cues and concerns and/or integrated the clinical tasks or patients' needs with a more holistic and patient-centred framework. This may therefore suggest that there may be greater variation between individuals irrespective of gender.

#### **6.1.2.2 Age of prescribers**

The demographic data collected for each participating professional shows that the average age of GPs was 49 years, the average age of nurses was 46 years and 42 years for pharmacists. Phase one found no correlation between the age of prescribers and proportion of missed or positive responses. The Royal College



of General Practitioners (RCGP) introduced their national training curriculum in 2006 which incorporated communication skills training and patient centred approaches in their curriculum and as part of their assessment. Prior to 2006, the provision of communication training would not necessarily have incorporated patient centred approaches. However, democratic consultation models which involve patient participation and adopt a more holistic approach have been employed in communication skills training for over two decades. For instance the influence of Balint (1957) groups, Byrne and Long's model of doctor patient communication (1976) and Pendleton's model (1984) would have been in circulation when GPs in this study commenced their training.

Given that the findings of recent research on doctor-patient communication over the past three decades suggests a lack of holism in consultation approaches employed by doctors (Pollock, 2005), the age of GPs in this study may be inconsequential. For instance, the findings of Butalid et al.'s (2014) longitudinal study which examined changes in doctor-patient communication of psychosocial problems between 1977 and 2008, may provide insight into other influencing factors. The authors found that empathy decreased over time which they attributed to doctors' focus on task-based communication (asking questions, giving information and advice). The authors attributed this to the influence of evidence based medicine which promotes symptom exploration to formulate diagnosis and inform treatment decisions. These and similar influences will be discussed in more depth in section 6.1.2.3.

The age of nurse and pharmacists is less likely to be an influential factor given that both professionals would have attended their independent prescriber training course relatively recently and therefore would have been recent recipients of communication skills training based on patient centred approaches. For nurses, this would be in addition to holistic based communication skills training received at undergraduate level. For nurses, communication skills have been an integral aspect of their training for longer than pharmacists since this skill is not taught in similar depth at undergraduate level. The influence of training and the implications of the study findings on training and support needs will be discussed later on in section 6.1.3.

### **6.1.2.3 Process Demands**

The second phase elucidated additional barriers to offering positive emotional labour. One of the main barriers highlighted was that some professionals appear more guided by a clinical agenda or follow a more structured format of a medication review. These types of encounters were characterised by the way in which the professional structures and directs the consultations with topics and questions, often closed questions, for the purpose of completing a computer template or in order to meet the professionals' (biomedical) agenda. These formulaic styles of consultation therefore influence the way in which the consultation is delivered – the structured nature of such consultations, perhaps to meet process demands, therefore becomes more mechanistic as opposed to humanistic or person centred which would enable patients increased opportunities to participate and voice their ideas, needs, fears, concerns and expectations to their prescriber.

One explanation for the employment of a more structured consultation style has been attributed to the QOF which is argued to be hindering professionals' ability to offer patient-centred approaches (Gillam & Siriwardena, 2011). It can be argued that this style of consultation may subsequently foreclose opportunities for patients to voice their concerns and participate in the consultation process which may therefore result in patients' cues and concerns remaining unvoiced.

The findings of this study echo previous observations identified in a study by Chew-Graham et al. (2013) who examined the extent to which the QOF influenced routine review clinics carried out by doctors for patients with long-term conditions. The authors found that consultations are oriented along biomedical lines in which doctors assume an expert position and patients become more passive and less likely to participate in the consultation process. The findings suggest that patients' agenda and concerns are often unvoiced and therefore unmet. Similarly, the findings of this study found that in structured, agenda driven consultations with GPs, nurses and pharmacists, patients were less likely to participate because there were less opportunities for them to do so. This finding was not necessarily identified in phase one due to the method employed to code cue-response sequences and therefore highlights the value of employing qualitative methods to examine patient-professional interactions. By

examining the consultation process, the analysis in phase two was able to identify those facilitators and barriers to patient centredness which includes patients' ability to participate or voice concerns during the consultation process.

However, although some authors have criticised QOF for being responsible for the erosion of patient centred care in general practice, this argument needs to be regarded with some caution. The main reason for this being that prior to the introduction of the QOF in 2004, previous studies found that patient centred approaches which consider patients' needs and concerns were not consistently enacted in consultations (Stimson and Webb, 1976; Tuckett et al., 1985; Barry et al., 2000). Moreover, claims to holism in general practice have been contested by authors who argue that commitment to patient centred care and the underpinning biopsychosocial model are more rhetoric than reality in that there is often a disconnection between what GPs say they do and what they do in practice (Checkland et al., 2008). The persistence of asymmetry in the medical encounter in terms of patient participation raises questions about whether QOF may be reinforcing pre-existing approaches to consultations or whether it is being used as a smoke screen to explain the lack of patient centred care.

While the process demands and biomedical orientation of QOF has been employed to account for its influence on the consultation styles of some prescribers, it does not account for all, in these findings. Another barrier to positive emotional labour and patient centred consultations highlighted in phase two findings were task focused consultations. This consultation style was typified by encounters in which the professional was distracted and therefore less attentive when they were attending to or completing certain tasks in the consultation (for example, taking blood pressure, temperature, examining the patient, typing or printing a prescription) and which have two principal effects on the patient. Firstly, patients may have limited opportunities to express their emotional cues and concerns due to the reduced opportunities to participate in the consultation. Secondly, when/if patients express concerns, professionals may not employ positive emotional labour such as offering an empathic response because they are distracted or focused on the task at hand. Consequently, when professionals are attending to tasks, patients' expressed concerns may remain unexplored or unacknowledged. Task oriented consultations have previously

been identified as barriers which foreclose opportunities for rapport building (Jones and Collins, 2007). Moreover, previous evidence suggests that task oriented consultations have also been employed as a defence against anxiety. In this instance, nurses have been shown to occupy themselves with tasks as a strategy to avoid engaging with patients' psychosocial concerns or worries (Menzies-Lyth, 1988). Further research would have to be undertaken to understand the extent to which task focused consultations with nurses, pharmacists and GPs are being employed as a defence against anxiety. Further research could also explore the role of such defence mechanisms underlying additional barriers (such as emotional disengagement and structured consultations) to the employment of positive emotional labour identified in this study.

While some professionals employed more structured, less open consultation styles, other professionals were able to employ more flexible and patient-centred consultations which integrated patients' needs with other clinical or other demands required of the professional. It could be argued that to be able to integrate the patient's agenda within a clinical or QOF driven agenda, within a person/patient-centred framework is challenging and requires skill, experience and ability to respond to the embodied needs of patients. It may therefore represent a particular challenge for newer prescribers, particularly pharmacists, who may have had less experience of providing consultations to patients within this framework. Pharmacists may also be familiarising themselves or gaining confidence in meeting the demands of QOF and other primary care practice systems while also having to utilise and put newly acquired skills and knowledge into practice. However, for those pharmacists who were able to offer a more holistic and integrated approach to the consultation, the 'newness' of prescribing within this role was clearly not the issue and therefore suggests that other factors at play.

Newness to the role cannot account for pharmacists who were more able to incorporate patients' bio-psychosocial needs into the consultation process. Neither can it account for the nurses and particularly GPs who had more experience in working with patients; it would appear that length of experience was not a predictor of consultation style and therefore differences may be explained by a range of factors discussed in this section such as the influence of

gender, training, or socio-cultural influences. The following section will discuss the influence of socio-cultural feeling rules on the way professionals manage emotionality within a dynamic encounter.

#### **6.1.2.4 Socio-Cultural Feeling Rules**

Sociocultural feeling rules can influence the management of emotionality for both patients and professionals and the employment of emotional labour. This may also include the way in which patients and different professional groups have been socialised to think/feel/act in particular ways.

Evidence of the influence of socio-cultural feelings may be found in different types of consultations styles and ways in which professionals respond to or manage patients' cues and concerns. For instance, one of the key barriers to positive emotional labour, emotional disengagement, was identified as a key barrier in phase two. This claim is also supported by phase one findings in the way that professionals biomedically redirect the consultation in response to a patients' cue or concern. In these encounters, disengagement was not necessarily explicit but exemplified often in what the professional did not communicate or when the professional did not engage with their patient on a more emotional level; namely lack of empathy in relation to the patient's emotional world or journey as expressed during the consultation or use of the voice of medicine employed to perhaps deflect or defer from engaging on an emotional level, as has been identified in previous research (Zimmerman et al., 2007, Barry et al., 2001).

Although emotional disengagement was evidenced across the three professional groups, it was more notably found in consultations with GPs. This observation is supported by phase one findings which found that GPs were significantly more likely to miss patients' cues and concerns, mainly through redirecting the consultation along biomedical lines, when compared to nurses and pharmacists.

To understand why doctors may be disengaging from patients' emotionality, it is useful to turn to previous research on this topic. It has been identified that sociocultural feeling rules have the potential to influence the way doctors

respond to emotionality. For instance, doctors may be influenced by a need to maintain face as expectations are placed on medics to adorn the 'cloak of competence' early on in their careers. It has been observed that doctors are frequently socialised during their medical training to distance themselves from the emotional demands of the work. This may lead to a dissonance between what a professional intrinsically feels and what they ought to feel/express (Fineman, 2003; Haas and Shaffir, 1987). Some evidence also suggests that doctors employ various strategies to distance themselves from emotional aspects of the consultation process as a way of managing their own emotions and anxiety (Kleinman, 1998). In this study, doctors' biomedical redirections and disengagement from patient's expressed emotionality could therefore serve to distance themselves from patients' emotionality.

Furthermore, the influence of socio-cultural feeling rules may be found in others aspects of professionals' consultation styles. For instance, the employment of task focused consultations has also been identified as a defence against anxiety since the professional is able to distance themselves from their patients and from emotionally demanding situations when they are engaged in a (biomedical) task (Menzies Lyth, 1988). Perhaps, healthcare professionals in this study were also employing task oriented consultations to similarly distance themselves from their patients' psychosocial worlds.

The previous sections have presented the range of micro and macro level influences on professionals' consultation styles. This highlights the complexity of this topic area in terms of understanding the ways in which health care professionals manage patients' emotionality and ways of accounting for this phenomena. The findings of this study and potential influences on the ways in which professionals' manage patients' emotionality has implications for the future training and support needs of health care professionals which will be discussed in the following section.

### **6.1.3 Support and training needs of healthcare professionals**

Given the embodied nature of health and illness, patients will continue to bring their emotionality into the healthcare encounter whether this is expressed

directly, indirectly or withheld. Whether patients have a diagnosed mental health problem, whether they are being managed for a chronic health condition, whether patients visit with an acute illness or for a myriad of psychosocial reasons, the findings from this study and previous evidence indicates that patients consistently bring their emotionality into consultations (Zimmerman et al., 2007).

Furthermore, when emotionality within the context of a healthcare encounter is viewed from within a social constructionist framework, drawing on the socio-cultural feeling rules influencing what can and cannot be expressed, it brings the dynamic nature of emotion communication and management into the frame. Given the complexities of such a dynamic encounter in which conscious and unconscious processes are influencing the ways in which feelings are communicated and managed it highlights the importance of ensuring healthcare professionals are equipped with the training and support to enable them to manage both their feelings and those of their patients.

While, there is evidence of such training in the undergraduate nursing and medical curricula (Bach and Grant, 2011) it is less evident in the training of pharmacists. Employing emotional labour can be rewarding but is also demanding on an individual's emotional resources. The healthcare professional has to manage competing demands as has been highlighted in this chapter. Moreover, as discussed in this chapter, there may be a myriad of factors influencing the ways in which emotionality is managed in the workplace which may constrain any healthcare professionals' ability to offer positive emotional labour.

Where alternative approaches to supportive relationships have been utilised in primary care, these have shown to have demonstrable positive effects for both patients and professionals. For example, Balint groups (Rabin, 2009) have been useful in providing interdisciplinary health care professionals with additional clinical and emotional support to assist individuals to manage and cope better with their emotionality and that of their patients. The groups provide a supportive forum for professionals to reflect upon their emotionality which provides insight and awareness of the relational dynamics presented in the patient-professional encounter. Balint groups enable professionals to listen

more empathetically to their patients while promoting interdisciplinary and experiential learning between different professional groups (Rabin, 2009).

The type of approach used in Balint groups is also reflected in Schwartz Centre Rounds© (Lown and Manning, 2010) which have recently been piloted in hospitals in the UK. Schwartz Centre Rounds© have widely used in the US and were introduced in the UK following recommendations in the Francis report (2013) to address the lack of compassion and social and emotional challenges of working in hospitals. These groups aim to provide a safe and supportive space where staff can openly discuss the pressures and emotional challenges of their work. Two of the principal outcomes from attending these groups are that they enable staff to be more compassionate and communicate better with colleagues and patients. The value of these groups for use in secondary care have been evidenced (King's Fund, 2011) and it would therefore be valuable to understand more about their transferability for use in primary care.

However, the inclusion of such groups within primary care would require financial resources. Perhaps the inclusion of supportive frameworks could be written in to the GMS contract and practices could be financially rewarded for introducing such schemes in their practice or/and supportive services could be procured through the clinical commissioning groups (CCGs).

Perhaps patient centred approaches could be financially rewarded through QOF although this may prove challenging to measure. Moreover, the effectiveness of financial incentives on process and approaches to healthcare are perhaps destined to fail given recent criticism directed at the detrimental effects of target driven incentives (Gillam, 2012). Such a critique of incentive schemes (such as QOF) is centred on the way they undermine professionals' intrinsic motivations to provide patient centred care (Mangin and Troop, 2007). Frey (1997) argues that an over reliance on external incentives may act as a disincentive on professionals' internal motivation for doing the job. Further criticism at target driven incentives is based on Goodhart's Law which posits that any measure introduced to control behaviour is unrealistic as behaviour often changes and is susceptible to manipulation or distortion upon the introduction of measures (Bevan and Hood, 2006). However, perhaps incentivising attendance at group based work such as Balint groups may offer a more realistic and workable solution.



Recently, the NHS introduced the 'Friends and Family Test' in line with the government's action plan to improve patients' experience of the NHS (NHS, 2013). Patients are invited to rate their NHS provider experience (i.e. on a hospital ward) in response to the following question: "How likely are you to recommend our [name of service] to friends and family if they needed similar care or treatment?" with follow up questions designed to elaborate on their answers. Importantly, patients' experiences are considered alongside the experiences of staff since it is recognised that staff provide better care when they feel satisfied and valued in their job. The overall scores are intended to act as a catalyst for change and to improve services quickly (NHS, 2013). The friends and family test has been implemented for in-patient care and A&E and is planned for roll-out in general practice in December 2014 (NHS, 2014).

Although the effectiveness and impact of this methodology on service improvement is yet to be evaluated, some criticism has been directed at the veracity and meaningfulness of the scoring system. Other concerns relate to the differences in the experiences of different staff and how these can be meaningfully interpreted. For instance, in the NHS annual staff survey, for example, doctors and managerial staff are more positive about the quality of care found in the organisation they work for when compared to nursing staff, allied health professionals or ambulance staff (Appleby, 2013). Additionally, questions have also been raised about the applicability of the friends and family test given its consumerist market origins. While this measure may assist non-healthcare consumerists in their procurement decision, its usefulness and application in a healthcare scenario may be unrealistic. For example, the majority of patients do not have a realistic choice about which A&E department they visit or choice about other specialist units such as maternity services. Therefore, it is argued that the friends and family test is presenting a false choice to patients (Cornwell, 2013).

Finally, a trial to evaluate whether patient feedback can improve the consultation skills of GP trainees as compared with regular communications skills training, found that patient feedback was no more likely to improve trainees' consultation skills compared with their regular training (Reinders, 2010). Therefore, it is unclear how patient feedback from the friends and family test will influence the

communication skills or consultation approaches of individual clinicians. As a result, meaningful research and evaluation will need to be conducted to determine the effectiveness and usefulness of the friends and family test.

More generally, the findings of this study and points of consideration in this chapter highlight the complexity of the relationship between patient and professional interaction and potential influences and challenges of employing a patient centred approach. Consequently, it may be over simplistic to assume that patient centred care could be meaningfully measured in ways that could influence or inform the way consultations are delivered.

Given the varying manifestations of anxiety (existential, interaction and entitlement anxiety) which patients and professionals may feel during the consultation (Fisher and Ereaut, 2012), it may be helpful to address additional ways of managing this in training but also in practice in terms of ongoing support and supervision. With increasing recognition of the manifestations and consequences of stress and burnout in GPs and nurses (Williams, 2012; Gray and Smith, 2009; Zapf & Holz, 2006) initiatives and interventions are being implemented to support healthcare professionals in their work. While healthcare professionals such as counsellors, psychotherapists, psychiatric nurses, clinical psychologists and psychiatrists (and many other professions besides) are provided with regular supervision in a supportive and reflective space to off load and discuss psychotherapeutic dynamics arising during client/patient contact, this structured support is currently not embedded within primary care. Given the psychosocial nature of patients' and professionals' worlds, perhaps GPs, nurses and pharmacists (and other health care staff) need to be offered psychotherapeutic support to help them manage their emotionality and that of their patients.

The effect of stress and burnout on patient-centred care has been well documented (Maben, 2008; Thomas et al., 2007). One study identified a positive correlation between job satisfaction and empathy in medical students and, conversely, a negative correlation between burnout (depersonalisation and emotional exhaustion) and empathy. In other words, stress can adversely affect patient centred care and empathy while empathy can increase job satisfaction and therefore reduce the potential for a health care professional to develop stress and burnout (Thomas et al., 2007). The increase of stress and burnout

has also been attributed to changes in the organization, financing and delivery of care which have added to existing pressures and stressors of the day-to-day work of a GP (Arnetz, 2001). Furthermore, there is evidence to indicate that there is a higher rate of mental illness and suicide in doctors as compared with individuals with a similar professional status (Caplan, 1994) and with higher rates of drug and alcohol dependency (Richings et al., 1986). The psychological distress experienced by doctors is further compounded by the societal stigma attached to mental illness with evidence that doctors avoid disclosure and help seeking behaviour early on in their medical training to avoid the associated shame associated with mental health problems (Chew-Graham et al., 2003).

Consequently, the need to provide ongoing support and training to acknowledge the breadth of emotional demand, may enable healthcare professionals to manage their emotions in a more supported environment. To address the increasing levels of stress and burnout, the concept of resilience has been suggested as a strategy to manage difficult emotions. Resilience refers to the skills, attitudes and approaches which can enable professionals to manage their emotionality more effectively (Epstein & Krasner, 2013). Using mindfulness practices to heighten self-awareness and knowing where and when to request support, health care professionals can develop resilience in their work. However, authors highlight that individual, community and institutional factors would need to be considered to enable individuals to develop resilience (Epstein & Krasner, 2013). While the authors acknowledge that wider factors need to be considered, it is important that any training which relies on the individual to identify strategies and inner resources to manage their emotionality, may place additional pressure on the individual to find their own solutions. A balance needs to be found between empowering individuals whilst recognising the wider socio-cultural or institutional level barriers which prevent individuals from seeking support. For instance, societal stigma attached to mental illness and intolerance of vulnerability amongst the medical profession (Chew Graham et al., 2003).

Some approaches to support are currently being provided intra-professionally. For example, the Royal College of General Practitioners have established a peer-to-peer network to provide newly qualified GPs with a five year support and mentoring network which they have named First5® (RCGP, 2013). In this

programme, GPs are supporting other GPs to provide support and mentoring to newly qualified GPs as it has been recognised that being newly qualified is often a daunting and isolating position to be in. However, while this may be a helpful initiative in providing peer support, perhaps both newly qualified and more experienced GPs may benefit from supervision provided by suitably qualified individuals experienced in providing this type of support in other professional groups, for example counsellors, or a professional who is independent from the practice.

Furthermore, it may also be beneficial to see a whole practice approach to initiatives that support all primary care staff who have contact with patients to enable them to manage their own emotions and those of their patients in a way that is helpful and sustainable. Reception staff, nurses, healthcare assistants, GP partners, salaried doctors, phlebotomists, healthcare visitors and many other staff who are integral to meeting the needs of patients in primary care need to be supported, their emotional labour valued and emotional needs met. Therefore, perhaps a whole-practice, person-centred approach is required to support the psychosocial needs of all staff. Person-centredness needs to be embedded into the culture of general practice yet it remains unclear who will be responsible for ensuring this is realised.

Finally, it is important that patient centred approaches including the employment of positive emotional labour and empathy continue to be incorporated into the training of any healthcare professional. Skills such as attentive listening, empathic communication, facilitation and responding to cues are embedded in the training curricula of healthcare professionals (von Fragstein et al., 2008). However, patient centredness is not simply something which can be taught within a communications skills training module, it needs to be ingrained into the ethos of and within the training of healthcare professionals and requires further reinforcement during placements and in practice. Given the socio-cultural influences on feeling rules, operating at individual, organisational and society level, the importance of self-reflective practice which is endorsed during professionals' training, needs to remain an important component in ongoing professional practice. The importance of ongoing self-reflection linked in with supervision could also address the realities of managing emotionality with the workplace and inform approaches to dealing with competing demands.

Evidence also suggests that while healthcare professionals may be taught communication skills which emphasise the importance of patient centredness and empathy, there is variability in terms of the way it is delivered in undergraduate and postgraduate training, as discussed in chapter two (Chant et al., 2002). Communication skills need to be underpinned by theory and evidence in terms of what is effective and beneficial for staff and patients. This would require robust research and evaluation methodologies to ensure it is effective. However, defining and measuring 'good' communication skills have been viewed as a complex and challenging endeavour. For instance, a review aiming to identify intervention strategies which aimed to improve communication skills found inconclusive results regarding what constitutes an effective intervention (Haywood et al., 2006).

It is therefore argued that until such procedures are in place, across the board, there will be an absence of quality research to attest the effectiveness of communication skills training for healthcare professionals. This will ultimately impact on the suitability of communication skills training delivered to health care professionals and the quality of communication skills required of professionals to interact with patients within a patient centred approach (Chant et al., 2002).

Additionally, no matter how effective the training, there may be a myriad of constraints to its operationalisation in practice. For instance, the prevailing socio-cultural feelings, discussed previously, within an institutional setting may prohibit a more patient centred approach. This has been evidenced recently in the findings of the Mid Staffordshire NHS Foundation Trust Public Inquiry which highlighted the importance of patient-centred care and underlying values/approaches of empathy and compassion. The report highlighted that patient centred care and the needs of patients were neglected due to systemic failings to 'tackle an insidious negative culture involving a tolerance of poor standards and a disengagement from managerial and leadership responsibilities' (Crown Report, 2013:3).

Patient centred care is not just an ideal to be hoped for and idealised, it requires leadership, commitment and understanding for it to be enacted and embedded

in to the heart of general practice and indeed any caring environment, as has been recently advocated by the King's Fund (2013).

#### **6.2.4 How do the methods employed in phase one and two compare in exploring this topic area?**

The overarching aim of this study was to understand how GPs, nurse and pharmacist prescribers manage patients' emotional cues and concerns in healthcare encounters in primary care. To explore this research question, a mixed-method study was employed as it was considered that a single method approach would not sufficiently address the complexity of the research topic – comparing, identifying and understanding professional responses and ways of managing patients' cues and concerns in healthcare encounters. The mixing of approaches to analysing the data and use of theory was employed to generate rich, comprehensive and robust accounts of the study phenomenon whose aim was to deepen understanding.

Phase one employed a coding framework to code the nature of patients' cues and prescribers' responses to them. This coding framework provided a useful method for coding and analysing a large data set and thus enabling more generalisable comparisons to be made between the professional groups. The second phase employed a qualitative approach which allowed for a more detailed analysis of emotion management within the healthcare encounter and to explore the facilitators and barriers to the employment of emotional labour. The strengths and limitations of the methodology will be discussed below.

##### **6.2.4.1 Strengths**

The advantage of using a coding framework such as the one developed in phase one, was its value in the coding and description of large data sets. This subsequently opens up the possibility of employing statistical techniques to make comparisons about the nature of patients' cues and concerns and

prescribers' 'missed' and 'positive' responses between the professional groups. It also enables the researcher to understand how variables (age, gender of prescriber and consultation length) may influence the type of prescriber response to patients' emotional cues and concerns.

The qualitative analysis of a sub-sample of phase one recordings has provided a more in-depth analysis of the process of emotional labour and has enabled a range of facilitators and barriers to be identified across the consultation process. The two phases allow for the light to be cast on different areas of the consultation process looking at interactional and other processes which influence the ways in which emotional labour is employed.

The strengths of one method can also compensate for the weaknesses in another. For example, the coding of professionals' responses as either missed or positive in phase one did not always portray a definitive picture of how professionals managed patients' cues and concerns within the consultation process. One such example of a coding anomaly was identified in the coding of professionals' responses in the opening of the consultation. During the opening of the consultation, professionals are encouraged to provide space in the consultation for patients to disclose their reasons (s) for visiting or to enable them to voice any concerns, questions, ideas about their condition or treatment (for example Marvel et al., 1999). In allowing patients to talk, professionals may not necessarily respond to or explore patients' cues and concerns and therefore responses which could be viewed as narrative continuers (such as *mmm*) were sometimes labelled as inadequate acknowledgements and which could have painted an inaccurate picture of the professionals' overall management of patients' cues and concerns, particularly when professionals addressed these concerns later on in the consultation process. The approach to the qualitative analysis therefore compensated for this limitation since it was more interested in the consultation process rather than the cue-response sequence alone.

The strengths of the qualitative analysis lie in its scope in identifying the barriers and facilitators and allowed for greater contextual information to be incorporated into the analytic process. For example, the qualitative analysis identified consultations that were more structured and often driven by the professionals' agenda or when meeting the process demands of QOF. It was identified that

this style of consultation narrowed opportunities for patients to express or communicate their concerns. Given that some pharmacist consultations tended to be more structured, this may have therefore foreclosed opportunities for patients to express their concerns. These findings may explain why patients communicated similar numbers of cues and concerns in pharmacist consultations despite having consultations that were significantly longer than GP consultations and nurse consultations. The findings of phase two therefore sheds light on some of the phase one results which at one level appear anomalous (such as the average cues and concerns expressed in GP, nurse and pharmacist prescriber consultations).

The qualitative analysis was also able to highlight the complexities and implications of the barriers and facilitators of emotional labour. For example, many of the facilitators were inextricably linked to each other and provided evidence of emotional labour as an on-going process and not solely evident in a singular response to a patient's cue or concern. This was evident in the process of empathy which often reflected a range of skills and approaches employed by professionals. For instance, this could be observed in the way professionals provided space for the patient's narrative without interruption or biomedical redirection and subsequently observed in the way that professionals communicated their understanding of the patient's feeling/meaning. Expressions of empathy suggest that healthcare professionals were listening and attuning to the patient's experiences and communicating that meaning and understanding back to the patient. These aspects of emotional labour reflect the different skills and approaches utilised by the healthcare professionals and how important it is to be engaged with the patient, to listen and communicate empathically.

#### **6.2.4.2 Limitations**

As has been discussed in the previous section, there were many challenges to using the type of coding framework employed in phase one. One of the principal challenges and one which was compensated for with the inclusion of a qualitative phase, was that the coding categories did not always do justice to the complexities of the healthcare interaction and were not able to accommodate



greater contextual information in order to inform decisions about coding. An additional challenge or drawback of using a clearly defined framework was its inflexibility in being able to identify nuances in responses or the range of responses within one category. For example, a professional's response could be coded as an 'acknowledgement' yet does not distinguish those extended responses from responses regarded as more minimal.

There were additional challenges in operationalizing the coding framework in terms of how to differentiate cues from concerns. Although the VR-Codes (Piccolo et al., 2011) definition of cue and concern appears unambiguous and relatively straightforward, in reality, it was often challenging, particularly without the visual cues to rely on. Sometimes it was challenging to judge whether a concern was direct or indirect since some expressions were ambiguous and therefore difficult to judge. Rather than coding expressions as either a cue or concern, the decision was taken to code cues and concerns collectively. It was considered that the healthcare professional's response to the patient's expression of emotion was important rather than imposing a pre-existing category onto a complex phenomenon.

In addition, the VR-Codes manual is considerably detailed and requires researchers to be trained in applying this coding system to the data. The external validity of any detailed coding system such as VR-Codes and, to a lesser extent, the coding framework employed in phase one of this study, may be problematic. Due to the extensive training involved in developing and using the adapted coding framework in this study which involved lengthy discussions and repeated listening and re-listening to cue-response sequences in specific consultations, it is uncertain how external researchers would replicate the coding of this or a similar data set. The external validity of the coding tool is therefore unknown. If the external validity of the coding framework is challenging to operationalise, it raises doubts about whether this coding framework could be applied to other data sets in future studies without extensive training with the current researchers. Therefore the opportunity to be able to compare research findings with previous findings may not be feasible. Nevertheless, in future research it is important to utilise a theoretically informed coding system and one which shows evidence of good internal validity in terms of inter-coder reliability. VR-Codes and its accompanying extensive coding handbook, represents such a

coding system and therefore receiving training in this system from the original authors would be a methodologically and theoretically sound option.

Considerable time has been spent agonising over the possible limitations of this methodology. In particular, for phase 2, the methodology could have included a post consultation interview de-brief or reflective phase which could have invited participating patients and professionals to consider how they felt about the consultation and to perhaps identify what helped and hindered emotion management. It would have been useful to understand more about patients' health and illness experience and feelings which arose for them in the consultation. Importantly, it may have identified what remained unspoken in the encounter.

In addition, I would have invited professionals to reflect on their understanding of the types of emotional concerns which arose in the consultation and to reflect on how they managed the patient's emotions. It may have been valuable to ask professionals to reflect on these issues and perhaps any challenges they faced by using a reflective diary technique either written or perhaps to reflect their thoughts verbally on the audio recorder (potentially in between consultations) given the time constraints that many professionals face. Diaries have long been used by patients to reflect on their experiences of health care and have also been used as a valuable method to encourage health care professionals to reflect on their practice (Theodosius, 2008). This would have enabled the researcher's interpretation of the recordings to be triangulated with those of patients and professionals. Despite the absence of patient and professionals' perspectives, other authors have highlighted that often patient and professional recollections or experiences of the consultation do not necessarily reflect those of the researchers' observations (Epstein et al., 2005).

Finally, it should be noted that potentially useful data gained from visual cues were not available to the coders due to the decision to audio record consultations and therefore the value of video-recorded consultations may be advisable for future studies.

These methodological issues have been addressed in section 6.6 'Future Research' which have taken these points into consideration in terms of future

research plans which can build on the findings and limitations of the methodology employed in this study.

The following section will reflect on the implications of these findings for patients and professionals while looking at the broader picture to understand future directions in terms of patient centredness and managing emotionality within healthcare settings.

### **6.3 Future Research**

Given the limitations of this methodology in terms of triangulating the data with patient and professionals' perspectives, it would therefore be useful to understand the views and experiences of patients and professionals regarding how emotionality is communicated and managed in health care encounters. One proposed methodology could employ an ethnographic case study using video recorded consultations with follow up interviews with patients & healthcare professionals in order to:

- Understand how patients felt and managed their emotionality during and after the consultation
- Understand how healthcare professionals felt and how they manage their emotions and those of their patients

In addition, this study has highlighted the need for health care professionals to be better supported to enable healthcare professionals to manage their emotionality and that of their patients. The focus of a separate study could therefore centre on how healthcare professionals in primary care (for instance, GPs, nurses, pharmacists, healthcare assistants and other professionals groups) currently manage their emotionality and that of their patients. The study could utilise ethnographic methods such as participant observational methods in which a researcher is situated in the practice to identify the dynamic and inter-relational employment of emotion work. Secondly, reflective techniques such as audio-diaries can be utilised to capture the ways in which professionals manage their own emotionality within their day-to-day work. Finally, focus groups or workshops could be employed to enable professionals to identify how they might

be best supported to manage their emotionality and that of their patients. Using such methods, the following aims of this study could be to:

- Understand how emotions are managed within the consultation process and wider institutional setting of general practice
- Understand how different professionals employ emotion work when working intra and inter professionally within general practice. For example how do nurses and GPs manage each others' emotionality.
- Use multi-perspective views to inform how best to support professionals to care for their patients – implications for practice culture, leadership and training

## **6.4 Conclusion**

This research set out to learn more about the ways in which 'new prescribers' (nurse and pharmacist prescribers) manage patients' emotional cues and concerns in healthcare encounters within a primary care setting. The key findings indicate that patients are communicating a range of cues and concerns in GP, nurse and pharmacist consultations and that there are both differences and similarities across and between the groups in the way that patients' emotionality is managed. By employing a mixed-method approach, it is possible to make comparisons, albeit tentative ones, across the groups while the addition of qualitative analysis provides further insight into the types of barriers and facilitators which impact on healthcare professionals' management of patients' emotional cues and concerns.

Furthermore, drawing on the work of Hochschild's (2003) emotion work theory and its subsequent application within a healthcare context, the aim of this work was to broaden the scope of emotion work theory and extend its use in other healthcare settings such as primary care. Although there are strengths and weakness of using this study methodology, the research process has contributed to understanding more about how positive emotional labour is employed across the groups and the barriers to doing so. One of the reasons for employing emotion work theory was its value in making emotional labour explicit so that it may be valued and recognised. This study has made visible the myriad of

facilitators and barriers to the employment of emotional labour by GPs, nurse and pharmacist prescribers.

In addition employing emotion work theory and its underlying social theory has enabled explanations to be offered on the way healthcare professionals employ emotional labour. This has identified other competing demands on healthcare professionals which appear to be influencing the delivery of emotional labour within a patient centred framework. This could include both process demands and constraints such as capitalisation processes which offer financial rewards for the tasks and checks associated with the management of specific chronic health conditions such as diabetes, hypertension and asthma. Yet, these incentivised processes appear to constrain the delivery of patient centred approaches for some healthcare professionals but not all and therefore suggest other factors at play. It has also considered and acknowledged how socio-cultural influences such as gender or/and socio-cultural feeling rules may have played a role in how emotionality is managed in the consultation by different individuals and by different professional groups. The ways in which different professional groups and individuals are socialised to manage their feelings and those of others may also play a role in this process.

This research has utilised the sociological theory of emotion work which has been influenced by Marxist and feminist traditions to deconstruct taken-for-grantedness in relation to the employment of emotional labour within an institutional setting. The research has drawn on the ontological assumptions of emotion work, social constructionism, to understand how feeling rules may influence the ways in which emotions are communicated and managed. Both theoretical and ontological positions have provided a useful framework with which to view the employment of emotional labour within an institutional setting such as primary care. Whereas, the application of emotional labour theory in healthcare has predominantly been focused on workers (particularly nurses) in secondary care (such as hospitals), it has been valuable to learn more about its usability and applicability for use within the context of primary care.

Principally, this applies to the relevance of emotional labour's Marxist and feminist theoretical underpinnings. In terms of its relevance to Marxist theory, this study's findings contest Hochschild's (2003) commodification thesis concerning the institutional ownership of workers' feelings. Rather, this study

has identified that process demands constituted outside the immediate organisational setting may be hindering approaches to offering positive emotional labour. Secondly, in examples where patients express gratitude for healthcare professionals' understanding, it may suggest that emotional labour involves the exchange of emotions and that potential (non-financial) rewards are gained from the act of caring. This would therefore question Hochschild's original commodification thesis which argued that emotional labour was viewed as a one-directional offering in the workplace context, without reciprocity. These findings reflect those points of difference raised by previous authors (Theodosius, 2008; Bolton, 2006) who question the applicability of the commodification thesis to a healthcare setting.

The findings of this study may highlight that when financial incentives become embedded in systems such as the QOF, it may be inadvertently affecting the consultation styles and approaches employed by healthcare professionals in general practice. Alternatively, given the gap between the rhetoric of patient centred approaches and their practice in day-to-day healthcare encounters, it is possible that financial incentives such as the QOF are being unfairly blamed for the absence of patient centred practice.

Perhaps the financial drivers of primary care are overshadowing or undermine patient centred care when process demands take priority in the consultation process. The findings of this study may highlight the implications of providing structured, mechanistic and less humanistic consultation approaches in which patients are reduced to symptoms to be managed while individuals are not invited or provided space to articulate their feelings and concerns. These process demands may consequently reduce opportunities for more compassionate and empathic approaches to understanding and managing patients' health and illness experiences and needs. Rather than a broadening of the clinical gaze, encapsulated in Engel's (1977) biopsychosocial model of health, the process demands of QOF and (over) reliance on the biomedical model may be reducing the clinical gaze and consequently jeopardising patient centred care.

However, as has also been highlighted, QOF and other process demands cannot solely be responsible for structured or task centred consultations. Firstly, not all healthcare professionals employed this approach to the consultation process despite having similar consultations (such as medication reviews) which would necessitate completing QOF templates. Secondly, evidence of less patient centred consultations which were driven more by the professionals' agenda was evident prior to the introduction of QOF (Barry et al., 2000). Consequently, process demands may constrain patient centred approaches but is only one explanation of a more complex process in which there may be a myriad of influences on patient-professional interaction.

This study has identified wide-ranging barriers and facilitators to the employment of positive emotional labour, defined as the act of caring involved in recognising the emotions of others (Smith, 2012). This study has identified that healthcare professionals across the three groups are employing a range of skills and approaches to delivering positive emotional labour. The qualitative analysis identified that positive emotional labour was being offered within a dynamic encounter between patient and professional. For example, by providing patients with space in the consultation, by not interrupting or redirecting, patients were able to participate and express their emotionality. In some instances there was a clear indication that patients' concerns had been acknowledged, when for example, patients expressed their agreement and/or their gratitude to their healthcare professional. This finding echoes Theodosius's (2008) claims that emotional labour is a 'collaborative therapeutic encounter' in which 'gratitude serves to sustain the care worker'.

As patient and professional views were not sought, it is not possible to understand the experiential impact and accompanying feelings of mutual understanding in relation to feeling understood (by the healthcare professional) and feeling appreciated (by the patient). However, given the findings of authors such as Theodosius (2008), one can only surmise about the possible reward and satisfaction that professionals can gain from having their emotional labour appreciated. If this appreciation sustains professionals, it may also serve to reinforce the benefits of positive emotional labour. Given the demands and pressures of working in primary care as previously discussed, it is important to acknowledge that (non-financial) rewards are potentially important to sustain

the caring work of professional in this environment. Furthermore, this may add weight to the arguments of authors (Theodosius, 2008; Bolton, 2006) who contest Hochschild's original commodification thesis in that emotional labour involves an exchange of emotions and is not a unilateral offering as Hochschild argued (2003).

The influence of financial systems on workers' satisfaction gained from offering positive emotional labour was also identified in a study by Rodriguez (2011). In her observations of and interviews with care home staff, the author found that the economic drivers of private care homes were limiting opportunities for care workers to develop caring relationships with their residents as time spent with residents was reduced. The findings indicated that care workers derived dignity from developing relationships with their residents and therefore curtailing opportunities to bond reduced their dignity at work and satisfaction with their job (Rodriguez, 2011).

In respect of emotional labour's feminist underpinnings, Hochschild (2003) posited that socially constructed beliefs in relation to the gendered nature of emotion work results in expectations of women to play the caring role. Although only tentative conclusions can be drawn from the findings of this study due to the small sample sizes of professionals, female GPs were found to respond more positively to patients' cues and concerns compared with their male colleagues. There were no clear differences between male and female pharmacists and all nurses were female with differences within these groups more attributable to individual differences in consultation styles. With the increasing feminisation of primary care, feminist debates around socio-cultural expectations will continue to be of relevance. If the current evidence supports the notion that female professionals manage patients' emotional cues and concerns more empathically, this will benefit patients but it is not known how these expectations may impact on the professional. Will this place additional pressure on the individual or will the rewards and job satisfaction gained from offering positive emotional labour reinforce and sustain the professional in their work? Additionally, with the increasing feminisation of general practice, how will this influence the practice of male colleagues? These questions reflect how emotional labour theory can usefully be employed within this setting and perhaps applied to other healthcare



environments other than secondary care where the predominant focus has been, to date.

To understand the differences in terms of the ways in which emotionality is managed in the health care encounter, this study and wider literature suggests that the reasons are complex and cannot be attributed to one factor alone. This chapter has drawn together the varying and interrelated socio-cultural, individual, structural and process level influences which may intercede and influence the ways in which patients' cues and concerns are managed.

This research has critically reflected on the strengths and limitations of using this methodology to understand the study topic. The process of critiquing the methodological and epistemological value and constraints of exploring and understanding emotionality within this context has highlighted the complexity of studying this particular study phenomenon, as discussed previously. Consequently it highlights that employing one method alone is perhaps insufficient to study and understand the complexity of emotionality expressed and managed within this context. It is therefore hoped that one of the contributions of this research is its value in informing methodological approaches for carrying out future research within this area and for learning more about how emotionality is managed within this setting in the future.

Finally, in making emotion work/labour explicit, it may be understood and valued by organisations, other professionals, patients and society in general. By making the skills or aspects of emotion work explicit, it has implications for the training and supervision of healthcare professionals. The training and supervision will consequently require an acknowledgement of the link between the more challenging aspects of emotion work and more positive ones. To support healthcare professionals in their work which can often be emotionally demanding, this study echoes previous calls for professionals to be equipped with strategies and support to enable healthcare professionals to manage difficult emotions and those of their patients. Ultimately, this confers benefits to patients in terms of having their emotional needs met, but also benefits healthcare professionals in terms of its potential to reduce stress and burnout and increase job satisfaction. To restate Denzin (1984), *'the study of emotionality must occupy a central place in all the human disciplines, for to be human is to be emotional'*. Given the centrality of emotionality within healthcare

encounters, this statement is equally applicable and relevant to the training and practice of any healthcare professional.

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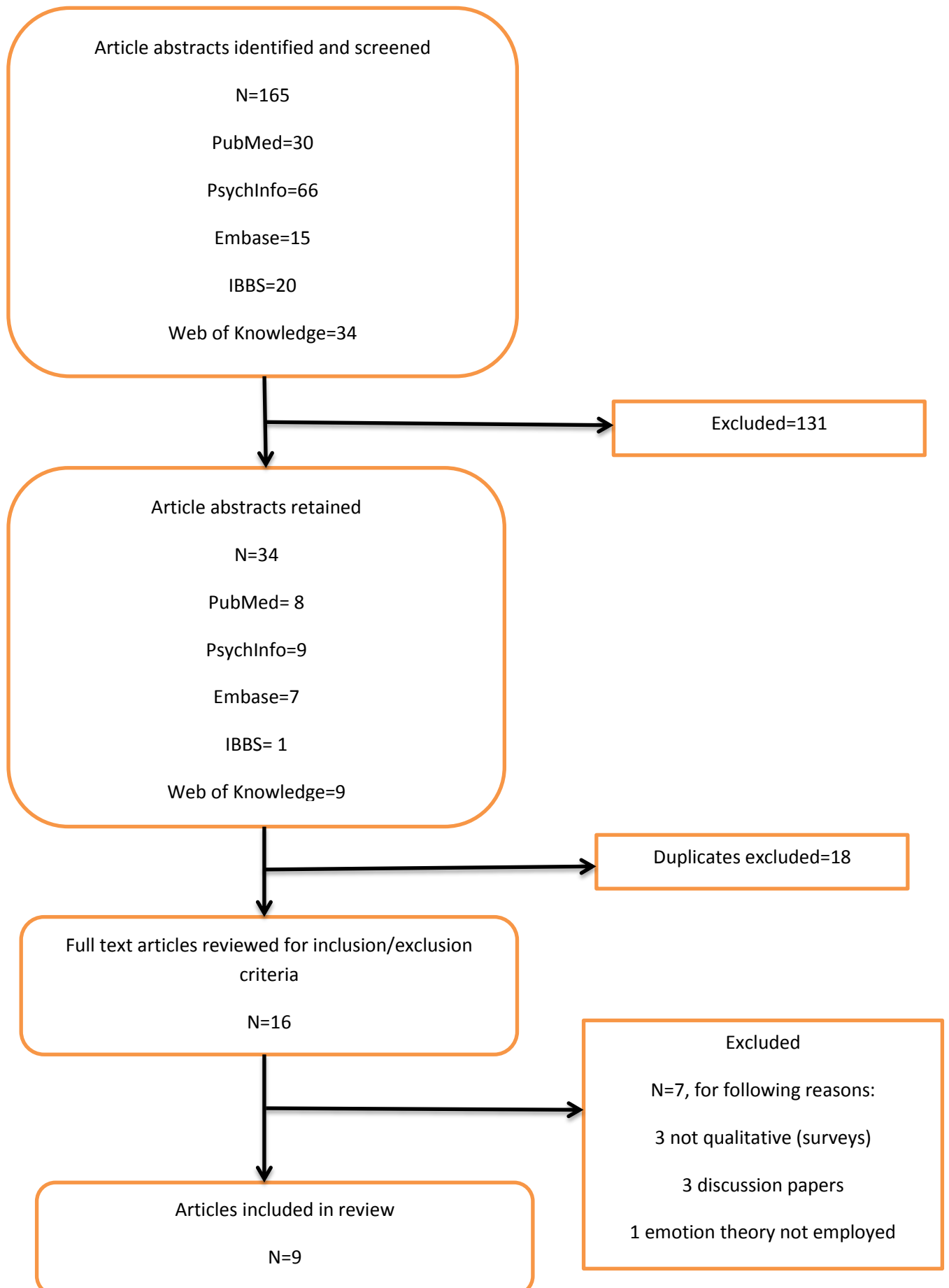
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## Appendix A

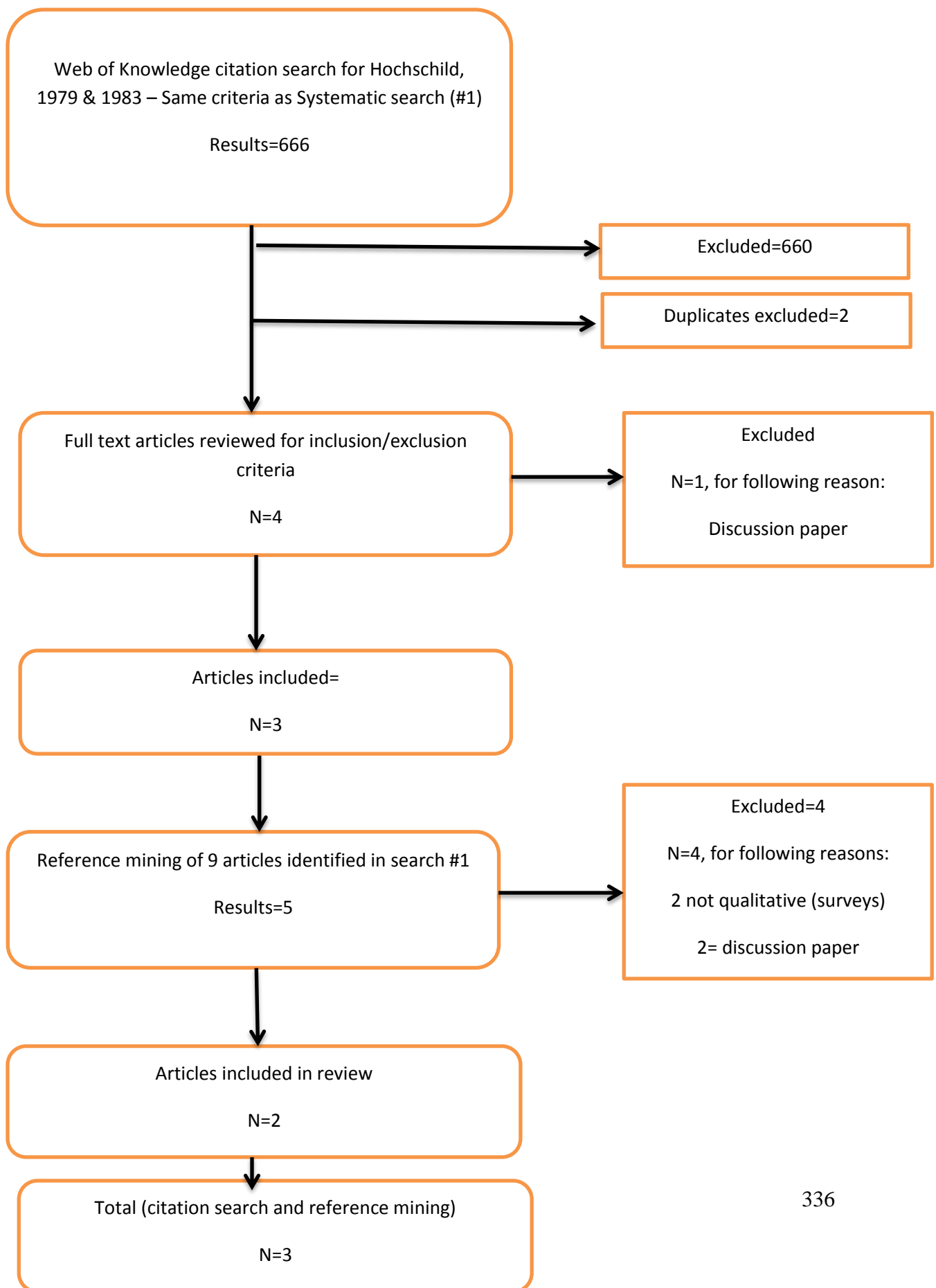
### Flow Diagram of Systematic Literature Search Results



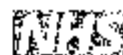


## Appendix B

### Flow Diagram of Citation Search and Reference Mining for Systematic Search



## APPENDIX C



### National Research Ethics Service Wiltshire Research Ethics Committee

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Fax: 01225 625720  
E-mail: [clinton.heck@ruh-bath.sage.nhs.uk](mailto:clinton.heck@ruh-bath.sage.nhs.uk)

23 September 2009

Professor Margrie Weiss  
Professor of Pharmacy Practice & Medicine Use  
Department of Pharmacy  
& Pharmacology  
University of Bath  
Bath  
BA2 7AY

Dear Professor Weiss

**Study title:** The Sociology of Prescribing: what can we learn from new prescribers?  
**REC reference:** 09/H0104/21  
**Amendment number:** 1  
**Amendment date:** 09 September 2009

The above amendment was reviewed by the Sub-Committee in correspondence on 4 September 2009

#### Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation

#### Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Questionnaire - For participants who saw a GP	2	09 September 2009
Questionnaire - For participants who saw a Nurse Prescriber	2	09 September 2009
Questionnaire - For participants who saw a Pharmacist Prescriber	2	09 September 2009
Questionnaire - For participants who saw a Community Pharmacist	2	09 September 2009
Notice of Substantial Amendment (non-CTIMPs)	1	09 September 2009

The Research Ethics Committee is an advisory committee to South West Strategic Health Authority  
The National Research Ethics Service (NRES) represents the data controllers within  
the National Patient Safety Agency and Research Ethics Committees in England

## **APPENDIX D**

### **Information about the Research**

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#### **Comparing the Consultations of Different Prescribers**

We would like you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the information carefully. Talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Ask us if there is anything that is not clear or you would like more information. Take time to decide whether or not you wish to take part.

#### **Part 1**

##### **What is the purpose of the study?**

This study aims to compare the consultations of different prescribers - general practitioners (GPs), nurses and pharmacists. Since 2004, nurses and pharmacists have been able to prescribe medicines to patients. We would like to compare the consultations of GPs, nurse and pharmacist prescribers in how they communicate with patients about medicines. To do this we would like to audio-record professional – patient consultations. If you agree to participate we will ask patients who come to see you if they would like to participate in the research. Patients will also be asked to complete a questionnaire about their consultation after their consultation is finished. We would also look at the patient's medical notes to see what medicines they are taking. In total we would like to recruit approximately 10 of your patients to participate in the research.

### **Why have I been invited?**

You have been invited to participate in the study because you are a GP, nurse prescriber or pharmacist prescriber in the south or south west of England or Wales.

### **Do I have to take part?**

It is up to you to decide. You can read through this information sheet which you will be able to keep. If you are interested in participating, please return the reply slip that came with this Information Sheet in the FREEPOST envelope and a member of the research team can come to your place of work and discuss the study with you without obligation. You would then be able to decide whether or not you wanted to participate. If you decide to participate, we will ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason.

### **What will happen to me if I take part?**

We would give you an audio-recorder which you would turn on with patients who have consented to participate in the study. Consenting patients will tell you when to turn on the audio-recorder as we will have recruited them in the waiting area prior to their appointment with you. Patients will be given a number which they will say at the beginning of the consultation so their identity will not be known. All information about you as a person will be kept confidential and anonymised in any study reports. We would like to record about 10 of your consultations with patients. Your participation in the study will only last as long as it takes to record these consultations which will probably be between one and three sessions. If you agree to participate, we will contact you after all the consultations have been recorded to see if you would like to participate in an interview. You will be able to say you do not want to participate in the interviews at that time.

### **What will I have to do?**

Complete the reply slip that came with this Information Sheet and return it in the FREEPOST envelope. We will contact you about participating in the research. We can come to your workplace to explain the study further. If you agree to participate, we will give you an audio-recorder to record approximately 10 of your consultations with patients.

### **What are the possible risks or disadvantages to taking part?**

There are no risks to you in taking part. However if you feel uncomfortable at any point during the recording of the consultations and would like the tape recorder turned off, please do so. If you change your mind after recording some or all of the consultations, please contact the researchers and we will remove your consultation recordings from the research.

### **What are the possible benefits of taking part?**

We cannot promise this study will help you but the information we get from this study will help improve the training of GPs, pharmacist and nurse prescribers in how they communicate with patients. We also hope this research will inform the future development of the nurse and pharmacist prescribing role.

### **What if there is a problem?**

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

### **Will my taking part in the study be kept confidential?**

Yes we will follow legal and ethical practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

## **Part 2**

### **What will happen if I don't want to carry on with the study?**

If you withdraw from the study after recording any consultations, you will need to let us know and we will destroy the recordings of your consultations and not use them in the research.

### **What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researcher (Professor Marjorie Weiss 01225 386787). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints procedure. In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action against the Primary Care Trust. The normal National Health Service complaints mechanisms will still be available to you.

### **Will my taking part in this study be kept confidential?**

All data (consultation recordings, the patients' medicines information and the patient questionnaires) will be stored securely in the care of Professor Marjorie Weiss. Only members of the research team will have access to this information. All information which is collected about you in the course of the research will be kept strictly confidential.

Consultations will be listened to by a researcher using a tool to look at the nature of the communication about medicines. The researcher will record information about the consultations onto a form which will be anonymised so as to not have any information identifiable to you as an individual. Information about the medicines that patients are taking and the patient questionnaires will also be anonymised.

Anonymised information from this study will be used to develop a training tool to help improve the communication skills of general practitioners, nurse and pharmacist prescribers. Data collected from this research will be stored for 5 years following completion of this study.

### **What will happen to the results of the research study?**

The results of this research will be used to develop training materials to improve the communication and consultation skills of GPs, pharmacist and nurse prescribers. The research will also be published as a report and in scientific journals. You will not be identified in any of the training materials, the report or publications. If you would like a copy of the research findings, please contact Professor Marjorie Weiss (01225 386787).

### **Who is organising and funding the research?**

The research is funded by a research grant from The Leverhulme Trust. The University of Bath is sponsoring this research.

### **Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed and approved by the National Research Ethics Committee and has received local research and development (R&D) approval from: Avon Primary Care Research Collaborative, Pan Bath Swindon Research Collaborative, North Somerset, Bristol, South Gloucestershire, Devon, East and West Berkshire and Birmingham East and North, Birmingham Teaching PCT, Lambeth, Lewisham & Southwark, Richmond & Twickenham, Wandsworth, Kingston, Merton & Sutton & Croydon, Brent, Ealing, Harrow, Hillingdon, Hammersmith & Fulham, Hounslow, Kensington & Chelsea, Westminster PCTs.

You can keep this sheet and if you would like to participate in the research you will be given a copy of the consent form to keep.

### **Further information and contact details**

If you would like further information about the research, please contact one of our researchers, **Ruth** or **Jo** on Tel: **01225 384165**, Email: [rr256@bath.ac.uk](mailto:rr256@bath.ac.uk). If you are unhappy with the study, please contact the research team led by Marjorie Weiss (01225 386787, Email: [m.weiss@bath.ac.uk](mailto:m.weiss@bath.ac.uk)).

**REPLY SLIP**

***I would / would not (delete one) be interested in helping with this research project:***

Name:

Address:

*If you are willing to participate:*

Preferred method of contact (*circle one*):

email

telephone

letter

Telephone: (please include the time of day when you will be available on this number)

Email:

**Nurse prescribers / Pharmacist Prescribers**

**Are you actually writing prescriptions?**

**Yes**

**No**



**If so, what is your clinical area of prescribing?**

**Thank you for your help!**

Please return using the FREEPOST envelope or send to:

*Professor Marjorie C Weiss*

*Department of Pharmacy & Pharmacology*

***FREEPOST*** SN1548

*University of Bath*

*Claverton Down*

*Bath*

*BA2 7AY*

Tele. 01225 386787

## APPENDIX E

Health Care Professional Number:

### Consent Form

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#### Comparing the Consultations of Different Prescribers

Name of Researcher:

*Please Initial Box*

1. I confirm that I have read and understand the Information Sheet dated 06 February 2009 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my legal rights being affected.

☐

3. I agree to take part in the above study.

☐

---

Name of Health Care Professional

Date

---

Signature

---

Name of Person taking consent

Date

---

*When completed, 1 for professional and 1 for researcher*

## **APPENDIX F**

### **Information about the Research**

#### **Comparing the Consultations of Different Prescribers**

We would like you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the information carefully. Talk to others about the study if you wish.

Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study.

Ask us if there is anything that is not clear or you would like more information. Take time to decide whether or not you wish to take part.

#### **Part 1**

##### **What is the purpose of the study?**

This study aims to compare the consultations of different prescribers - general practitioners (GPs), nurses and pharmacists. Since 2004, nurses and pharmacists have been able to prescribe medicines to patients. We would like to compare the consultations of GPs, nurse and pharmacist prescribers in how they communicate with patients about medicines. To do this we would like to audio-record your consultation with your doctor, pharmacist or nurse. We would also like to look at your medical notes to see what medicines you are taking and for you to fill out a questionnaire at the end of your consultation.

##### **Why have I been invited?**

You have been invited to participate in the study because you have an appointment with a doctor, nurse or pharmacist prescriber. The doctor, nurse or pharmacist you are seeing today has already agreed to participate in the study.

### **Do I have to take part?**

It is up to you to decide. We will describe the study and go through this information sheet, which we will then give to you. We will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

### **What will happen to me if I take part?**

You will see your doctor, pharmacist or nurse and ask them to turn on the tape recorder so the sound of your consultation will be recorded. You will say a number at the beginning of the consultation so your identity will not be known. All information about you as a person will be kept confidential and anonymised in any study reports. You will also be given a questionnaire to fill out after your consultation. Your participation in the study will only last as long as your consultation and the time needed for you to fill out the questionnaire afterwards. There will be no other follow-up unless you indicate on the questionnaire that you would like to be contacted in the future about a further interview. If you agree, we will also look at your medical notes afterwards to see what medicines you are taking.

### **What will I have to do?**

You will ask your doctor, nurse or pharmacist to turn on the tape recorder, say your study number at the beginning of the consultation and fill out a questionnaire at the end.

### **What are the possible risks or disadvantages to taking part?**

There are no risks to you in taking part. However if you feel uncomfortable at any point during the consultation and would like the tape recorder turned off, please ask your prescriber to do this. If you change your mind after leaving the consultation, please contact the researchers and we will remove your consultation recording from the research.

### **What are the possible benefits of taking part?**

We cannot promise this study will help you but the information we get from this study will help improve the training of GPs, pharmacist and nurse prescribers in how they communicate with patients.

### **What if there is a problem?**

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

### **Will my taking part in the study be kept confidential?**

Yes we will follow legal and ethical practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

## **Part 2**

### **What will happen if I don't want to carry on with the study?**

If you withdraw from the study after the consultation, you will need to let us know and we will destroy the recording of your consultation and not use it in the research.

### **What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researcher (Professor Marjorie Weiss 01225 386787). If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints procedure. Details can be obtained from the surgery or clinic.

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds

for a legal action against the Primary Care Trust. The normal National Health Service complaints mechanisms will still be available to you.

### **Will my taking part in this study be kept confidential?**

All data (consultation recordings, information about the medicines you are taking and questionnaires) will be stored securely in the care of Professor Marjorie Weiss. Only members of the research team will have access to this information. All information which is collected about you in the course of the research will be kept strictly confidential.

Consultations will be listened to by a researcher using a tool to look at the nature of the communication about medicines. The researcher will record information about your consultation onto a form which will be anonymised so as to not have any information identifiable to you as an individual.

Questionnaires will be given a number and no information identifiable to you as an individual will be kept. Information collected about the kind of medicines you are taking will be stored on a form with the same number.

Anonymised information from this study will be used to develop a training tool to help improve the communication skills of general practitioners, nurse and pharmacist prescribers. Data collected from this research will be stored for 5 years following completion of this study.

Your GP will be aware of your participation in this research. As the end of the study, he/she may receive feedback on their communication which will be anonymised and not identifiable to you as an individual.

### **What will happen to the results of the research study?**

The results of this research will be used to develop training materials to improve the communication and consultation skills of GPs, pharmacist and nurse prescribers. The research will also be published as a report and in scientific journals. You will not be identified in any of the training materials, the report or publications. If you would like a copy of the research findings, please contact Professor Marjorie Weiss (01225 386787).

### **Who is organising and funding the research?**

The research is funded by a research grant from The Leverhulme Trust. The University of Bath is sponsoring this research.

Your GP, nurse or pharmacist prescriber is not being paid to help with this research.

### **Who has reviewed the study?**

All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights, well-being and dignity. This study has been reviewed by Wiltshire Research Ethics Committee and the local Primary Care Trust's Research and Development Office for Devon PCT.

You can keep this sheet and if you would like to participate in the research you will be given a copy of the consent form to keep.

### **Further information and contact details**

If you would like further information about the research, please contact one of our researchers, **Ruth** or **Jo** on Tel: **01225 384165**, Email: [rr256@bath.ac.uk](mailto:rr256@bath.ac.uk).  
If you are unhappy with the study, please contact the research team led by Marjorie Weiss (01225 386787, Email: [m.weiss@bath.ac.uk](mailto:m.weiss@bath.ac.uk)).

If you are unhappy with the study, please contact the research team led by Marjorie Weiss (01225 386787, Email: [m.weiss@bath.ac.uk](mailto:m.weiss@bath.ac.uk)).

## APPENDIX G

Patient Number:

### Consent Form

Comparing the Consultations of Different Prescribers

Name of Researcher:

*Please Initial Box*

1. I confirm that I have read and understand the Information Sheet dated 6 February 2009 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason, without my medical care or legal rights being affected.

3. I understand that relevant sections of my medical notes and data collected during the study may be looked at by individuals from the University of Bath where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

4. I agree to take part in the above study.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name of Person taking consent

\_\_\_\_\_  
Date



## APPENDIX H

Coding Sheet (version 2)

Prescriber: GP/NP/PhP  Summary of Patient Clues and Physician Responses   Length of Interview =  Total Number of Patient Clues =  Total Number of Patient Initiated Clues =  Total Number of Prescriber Initiated Clues =  Total Positive Prescriber Responses =  Total Missed Opportunities =		
Patient Clue #1  Type of clue:  Emotional <input type="checkbox"/>  Social <input type="checkbox"/>	Direct <input type="checkbox"/>  Indirect <input type="checkbox"/>	Positive <input type="checkbox"/>  Negative <input type="checkbox"/>
Patient or physician Initiated? Circle   If physician initiated, how? (e,g, open or closed question?)		

More Detail about Clue (verbatim quote)

*Emotional:* (1) Feelings about biomedical condition e.g. frustration, guilt, denial, fear (2) Medication related (3) Aging (4) Stress e.g. work, other global life concerns (5) Bereavement (6) Concerns about life changes e.g. last child to go to college, wife in nursing home, retirement (7) Other (state)\_\_\_\_\_

*Social:* (Prescriber can learn more about patient's life e.g. information about sports, weather, holidays) (verbatim quote)

Physician Response to Clue (verbatim quote)

Positive Response:

Acknowledgement \_\_\_\_\_

Encouragement, Praise or Reassurance \_\_\_\_\_

Supportive \_\_\_\_\_

Pursuit \_\_\_\_\_

Missed Opportunity:

Inadequate Acknowledgement \_\_\_\_

Inappropriate humour \_\_\_\_\_

Denial \_\_\_\_\_

Terminator \_\_\_\_\_

Re-direction \_\_\_\_\_

If clue is missed, how many times does the patient subsequently mention the concern? \_\_\_\_\_

## APPENDIX I

Coding Sheet (version 3)

Prescriber: GP/NP/PhP  Summary of Patient Clues and Physician Responses   Length of Interview =  Total Number of Patient Clues =  Total Number of Patient Initiated Clues =  Total Number of Prescriber Initiated Clues =  Total Positive Prescriber Responses =  Total Missed Opportunities =		
<b>Patient Clue #1</b> Type of clue:  Emotional <input type="checkbox"/>  Social <input type="checkbox"/>	Direct <input type="checkbox"/>  Indirect <input type="checkbox"/>	Valence  Positive <input type="checkbox"/>  Negative <input type="checkbox"/>
Patient or physician Initiated? Circle    If physician initiated, how? (e,g, open or closed question?)		

More Detail about Clue (verbatim quote)

*Emotional:* (1) Feelings about biomedical condition e.g. frustration, guilt, denial, fear (2) Medication related (3) Aging (4) Stress e.g. work, other global life concerns (5) Bereavement (6) Concerns about life changes e.g. last child to go to college, wife in nursing home, retirement (7) Other (state)\_\_\_\_\_

*Social:* (Prescriber can learn more about patient's life e.g. information about sports, weather, holidays) (verbatim quote)

Physician Response to Clue (verbatim quote)

Positive Response:

Acknowledgement \_\_\_\_\_

Encouragement, Praise or Reassurance \_\_\_\_\_

Supportive \_\_\_\_\_

Pursuit \_\_\_\_\_

Other (describe)

Missed Opportunity:

Inadequate Acknowledgement \_\_\_\_

Lack of praise \_\_\_\_\_

Inappropriate humour \_\_\_\_\_

Denial \_\_\_\_\_

Terminator \_\_\_\_\_

Re-direction \_\_\_\_\_

Postponing \_\_\_\_\_

Interrupting \_\_\_\_\_

Other (describe) \_\_\_\_\_

If clue is missed, how many times does the patient subsequently mention the concern? \_\_\_\_\_

## APPENDIX J

Coding Sheet (version 4)

Prescriber: GP/NP/PhP

### **Summary of Patient Empathic Opportunities & Physician Responses**

Length of Interview =

Total Number of Patient Clues =

Total Number of Patient Initiated Clues =

Total Number of Prescriber Initiated Clues =

Total Positive Prescriber Responses =

Total Missed Opportunities =

### **Patient Clue #1**

Concern (Direct) ☐

Cue (Indirect) ☐

### **Patient or physician Initiated?** Circle

If physician initiated, how? (e,g, open or closed question?)

### **More Detail about Clue** (verbatim quote)

(1) Feelings about biomedical condition e.g. frustration, guilt, denial, fear, anxiety, distress, pain, surprise, shock, sadness, disgust, shame or other (state)\_\_\_\_\_

(2) Impact of illness/symptoms on daily life

(3) Medication related (4) Lifestyle (5) Aging (6) Stress e.g. work, other global life concerns (7) Bereavement (8) Concerns about life changes e.g. last child to go to college, wife in nursing home, retirement

(9) Social (hobbies, holidays) (10) Other (state)\_\_\_\_\_

**Physician Response to Clue** (verbatim quote)

**Positive Response:**

Acknowledgement \_\_\_\_\_

Encouragement, Praise or Reassurance \_\_\_\_\_

Supportive \_\_\_\_\_

Pursuit \_\_\_\_\_

Other (describe)

**Missed Opportunity:**

Inadequate Acknowledgement \_\_\_\_

Lack of praise \_\_\_\_\_

Inappropriate humour \_\_\_\_

Denial \_\_\_\_

Terminator \_\_\_\_

Re-direction \_\_\_\_\_

Postponing \_\_\_\_\_

Interrupting \_\_\_\_\_

Other (describe) \_\_\_\_\_

Information withheld\_\_\_\_\_

If Clue missed, how many times does the patient subsequently mention it?

\_\_\_\_\_

## APPENDIX K

Coding Sheet (version 4)

<p>Prescriber: GP/NP/PhP</p> <p>Summary of Patient Empathic Opportunities &amp; Physician Responses</p> <p>Length of Interview =</p> <p>Total Number of Patient EO's =</p> <p>Total Number of Patient Initiated EO's =</p> <p>Total Number of Prescriber Initiated EO's =</p> <p>Total Positive Prescriber Responses =</p> <p>Total Missed Opportunities =</p>		
<p><b>Patient EO #1</b></p> <p>Type of EO:</p> <p>Emotional <input type="checkbox"/></p> <p>Social <input type="checkbox"/></p>	<p>Concern <input type="checkbox"/></p> <p>Cue <input type="checkbox"/></p>	
<p><b>Patient or physician Initiated?</b> Circle</p> <p>If physician initiated, how? (e,g, open or closed question?)</p>   		

**More Detail about EO** (verbatim quote)

*Emotional:* (1) Feelings about biomedical condition e.g. frustration, guilt, denial, fear (2) Medication related (3) Aging (4) Stress e.g. work, other global life concerns (5) Bereavement (6) Concerns about life changes e.g. last child to go to college, wife in nursing home, retirement (7) Other (state) \_\_\_\_\_

*Social:* (Prescriber can learn more about patient's life e.g. information about sports, weather, holidays) (verbatim quote)

**Physician Response to Clue** (verbatim quote)

**Positive Response:**

Acknowledgement \_\_\_\_\_

Encouragement, Praise or Reassurance \_\_\_\_\_

Supportive \_\_\_\_\_

Pursuit \_\_\_\_\_

Other (describe)

**Missed Opportunity:**

Inadequate Acknowledgement \_\_\_\_

Lack of praise \_\_\_\_\_

Inappropriate humour \_\_\_\_

Denial \_\_\_\_

Terminator \_\_\_\_

Re-direction \_\_\_\_\_

Postponing \_\_\_\_\_

Interrupting \_\_\_\_\_

Other (describe) \_\_\_\_\_

If EO missed, how many times does the patient subsequently mention the concern? \_\_\_\_\_



## APPENDIX L

### Coding Sheet (version 5)

Prescriber: GP/NP/PhP/CP   Pr Gender: ☐ F   ☐ M   Pt Gender: ☐ F   ☐ M

#### **Summary of Patient Cues & Concerns (C/C) and Prescriber Responses**

Length of Interview =

Total Number of Patient C/C=

Total Number of Patient Initiated C/C =

Total Number of Prescriber Initiated C/C =

Total Positive Prescriber Responses =

Total Missed Opportunities =

#### **Patient C/C #1**

Concern (Direct) ☐

Cue (Indirect) ☐

#### **Patient or Prescriber initiated?** Circle

If physician initiated, how? (e,g, open or closed question?)

#### **More Detail about C/C** (verbatim quote)

Time

(1) Feelings about biomedical condition e.g. frustration, guilt, denial, fear, anxiety, distress, pain, surprise, shock, sadness, disgust, shame

(2) Impact of illness/symptoms on daily life

(3) Medication related (4) Lifestyle (5) Aging (6) Stress e.g. work, other global life concerns (7) Bereavement (8) Concerns about life changes e.g. last child to go to college, wife in nursing home, retirement

(9) Social (hobbies, holidays)

**Physician Response to C/C** (verbatim quote)

**Positive Response:**

- 1) Acknowledgement
- 2) Pursuit
- 3) Encouragement, praise or reassurance & supportiveness
- 4) Other

**Missed Opportunity:**

- 1) Inadequate Acknowledgement
- 2) Re-direction
- 3) Interrupting
- 4) Other i.e. postponing lack of praise, inappropriate humour, denial

If C/C missed, how many times does the patient subsequently mention it?

\_\_\_\_\_

**Impressions of consultation:**

## APPENDIX M

### Levinson Coding Guidance

#### Definitions

**Cue/Clue**

Any expression introducing new contents by variations in voice quality, content, or speech and indicating that in the consultation there is still something not explored or not dealt with enough. Refers to expectations, ideas, feelings, symptoms, somatic or emotional worries experienced by the patients

**Concern**

A clear/direct and unambiguous expression of unpleasant current or recent emotion.

(VR-codes, 2009)

#### Cues and concerns

Only code for one type of cue/concern e.g. emotion about biomedical condition – only tick one box

(a) Emphatic/emotive Language – emotive or language used to emphasise an emotion or feeling about a symptom e.g. use of metaphor “ I am shattered” or “It’s been hellish or a nightmare”

(b) Minimisers – minimisers such as ‘a little bit’; ‘sort of’ ‘just’ are used to minimise an utterance and is often use to (i) maintain face e.g. when patient is down playing extent of illness or experience of unpleasant symptoms (ii) Minimisers are also used to save face e.g. when patient is attempting to downplay any criticism of the prescriber i.e. when treatment isn’t working or when patient’s symptoms haven’t improved

(c) Utterance is **not** a clue if patient is merely relaying information about biomedical concern to prescriber unless accompanied by an underlying emotion e.g. ‘I have a rash on my leg and it’s itchy’ compared to ‘I’ve a rash on my leg and it’s so itchy, it’s driving me mad’

(d) If several cues appear in one narrative and which includes different turns, code as separate cues but if several cues appear in one turn, code as one cue

(e) If utterance is ambiguous e.g. if patient is providing information about symptoms, particularly in response to a question, ask yourself if anything useful is revealed if the clue was pursued. Is it suggestive of something else or is simply information with no hidden agendas.

(f) Any utterance about the past which is not relevant to the patient's current biopsychosocial world and if you feel has previously been addressed or discussed in a consultation do not code as a cue or concern

(g) Don't code any social cues unless it reveals useful information about person's biopsychosocial world

(h) If you're really uncertain about whether an utterance is a clue or not highlight it and discuss with another coder. If the second coder is also undecided, grab a G&T, agonise for a bit and then agree to not code

## **Responses**

Only code for one type of response

### Positive Responses

(**ACE** - **A**cknowledgement, **C**larification, **E**ncouragement)

- (a) When the pr acknowledges, validates or identifies with a patient's emotional cues/concerns e.g. the unpleasantness of pain or continuous bleeding. Shows pr is actively listening and patient feels heard.
- (b) When the pr pursues a clue by exploring/clarifying feelings about their cues/concerns especially when patient's when patients are striving to maintain face e.g. to avoid shame attached with not being able to cope or when having to discuss embarrassing topics i.e. menstrual bleeding, libido or weight gain
- (c) When prescriber encourages patient's to talk more about their thoughts, feelings or beliefs about their biopsychosocial world

- (d) When pr offers genuine reassurance about a patient's cue/concern using appropriate language i.e. lay language

### Missed Responses

- (a) Does the response relate to the cue or is it a biomedical response/redirection? If the biomedical response relates to the patient's cue about a particular symptom, code as missed – redirection. A biomedical response would include e.g. closed questions for diagnostic purposes (when did that happen? Can you bend your arm for me?), use of medical jargon or topic switching (do you smoke?) to avoid dealing with emotion or sensitive issues
- (b) Is the prescriber's response a strategy to for him/her to take control of the consultation or to redirect the patient's agenda e.g. by asking a question e.g. GP HO650 'Work, how's that?' in response to a patient who is experiencing stress
- (c) If the prescriber interrupts the patient before they have completed their turn, and which prevents the patient from completing a potential cue, code as interruption **but**
- (d) If the prescriber interrupts with a continuer, recompleter (i.e. the doctor who finishes patients' sentences) or positive response e.g. 'okay' and patient is able to complete their turn, then code as a positive response.
- (e) Code platitudes or perfunctory responses or prescriber merely following 'script' as a missed response and is particularly evident when the prescriber is not actively listening i.e. when distracted e.g. when typing or attending to another task. Response needs to sound genuine.
- (f) If pr says nothing, code as inadequate acknowledgement

## APPENDIX N

Intercoder Reliability Test Using Positive Agreement (Nov 2010)

			JP		RR			Intercoder Positive Agreement/Reliability			
	Recording	Total EO	Positive	Missed	Total EO	Positive	Missed	Same EOs	Positive Agreement of Cues and Concerns Identified	Same response	Positive Agreement of Same Response
1	298	11	7	4	8	3	5	5	53	4	80
2	294	10	6	4	9	3	6	7	77	5	71
3	320	3	1	2	1	1	0	1	33	0	0
4	319	4	3	1	2	2	0	2	50	1	50
5	273	7	4	3	6	4	2	6	66	5	83
6	278	5	2	3	3	2	1	3	60	3	100
7	117	4	1	3	3	0	3	1	50	1	100
8	114	4	2	2	4	0	4	4	100	2	50
9	580	8	5	3	10	3	7	6	75	4	66
10	573	7	4	3	5	1	4	4	61	2	50
	Totals	63			51			39	625		650

Mean Av. Positive Agreement	62%	65%
-----------------------------------	-----	-----

Positive  
Agreement  
Formula  
(Szklo &  
Nieto, 2007)

$(2a) / (2a+b+c) =$

Example using DE298

$(10) / (10+6+3) =$

## Appendix O

### Summary of Consultations Included in Sub-Sample for Qualitative Analysis

<b>Professional Group</b>	<b>Study ID</b>	<b>Basic professional demographics</b>  <b>Patient or prescriber initiated consultation</b>	<b>Length of Consultation</b>	<b>Brief Description of Patients' Reason (s) for Visiting</b>	<b>Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation</b>	<b>Total Cues and Number of Positive &amp; Missed Responses Identified in Quantitative Phase</b>
General Practitioners (GPs)	115	GP Male 46 yrs Pt initiated	6.75	A female patient complains about side effects of antibiotics and protracted respiratory tract infection for which she has been prescribed several courses of antibiotics.	The GP wants to send a sputum sample off to see if the patient has an infection yet in the process overlooks the patient's concerns about the on-going infection. The GP sounds dismissive/defensive in defending his clinical decision	Total cues=2 No Positive Responses=1 No Missed Responses=1



Professional Group	Study ID	Basic professional demographics  Patient or prescriber initiated consultation	Length of Consultation	Brief Description of Patients' Reason (s) for Visiting	Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation	Total Cues and Number of Positive & Missed Responses Identified in Quantitative Phase
	171	GP Male 51 yrs Pt initiated	11.66	From opening. A female patient has come in to seek advice about whether or not she should increase her dose of sleeping tablets because she has difficulty sleeping.	<p>The GP is concerned that she may become addicted to the sleeping tablets and so presents a clinical line of defence for not increasing the dose and instead suggests a website, patient.co.uk, for advice about non-pharmaceutical interventions to assist with sleeplessness. The GP also informs the patient that not sleeping doesn't do you any harm. It appears that the GP does not always acknowledge the full extent of the impact that not sleeping has on her life and does not enquire why she is not sleeping.</p> <p>The patient who is very well informed about a range of strategies to help her sleep is desperate to find a solution as not sleeping is making her feel 'shattered'.</p>	Total cues= 2 No Positive Responses= 0 No Missed Responses= 2

<b>Professional Group</b>	<b>Study ID</b>	<b>Basic professional demographics</b>  <b>Patient or prescriber initiated consultation</b>	<b>Length of Consultation</b>	<b>Brief Description of Patients' Reason (s) for Visiting</b>	<b>Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation</b>	<b>Total Cues and Number of Positive &amp; Missed Responses Identified in Quantitative Phase</b>
	252	GP Male 55 yrs Pt initiated	14.30	From opening. A male patient has come to seek advice about and convey concerns about medications he is taking. He is concerned about contraindications and the side effects of one medication which is dulling his brain, making him listless.	The doctor overlooks the patient's cues and concerns about the medication and by keeping it clinical, some of the patient's concerns are not addressed or acknowledged. In response to the patient's concerns about medication side effects, the doctor stalls the patient's concerns or backgrounds them by recommending patient.co.uk and does not acknowledge the impact of the medication side effects on the patient.	Total cues= 8 No Positive Responses= 2 No Missed Responses= 6

<b>Professional Group</b>	<b>Study ID</b>	<b>Basic professional demographics</b>  <b>Patient or prescriber initiated consultation</b>	<b>Length of Consultation</b>	<b>Brief Description of Patients' Reason (s) for Visiting</b>	<b>Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation</b>	<b>Total Cues and Number of Positive &amp; Missed Responses Identified in Quantitative Phase</b>
	650	GP Male 53 yrs Pt initiated	5.56	From opening. A young woman has come back to see a different GP as she has reoccurring headaches and which may be attributable to psychosocial factors occurring in her lifeworld.	The doctor does not consistently attend to the patient's health and illness experiences. The consultation sounds rushed and there is frequent typing.	Total cues= 9 No Positive Responses= 4 No Missed Responses= 5
	295	GP Female 40 yrs Pt initiated	14.25	From opening. A male patient has a protracted respiratory infection and feels short of breath. The patient also has an asthma for which he uses inhalers. He also talks about dizzy	The GP is attentive and sympathetic to the patient's cues/concerns and appears to be actively listening e.g. when she reflects back some of the patient's c/c and acknowledges how bad he has been feeling.	Total cues= 9 No Positive Responses= 7 No Missed Responses= 2

<b>Professional Group</b>	<b>Study ID</b>	<b>Basic professional demographics</b>  <b>Patient or prescriber initiated consultation</b>	<b>Length of Consultation</b>	<b>Brief Description of Patients' Reason (s) for Visiting</b>	<b>Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation</b>	<b>Total Cues and Number of Positive &amp; Missed Responses Identified in Quantitative Phase</b>
				spells and heart palpitations (which he's been treated for). The doctor and patient sound familiar with each other.		
	63	GP Male 42 yrs Pr initiated	14.45	A female patient has been invited in to discuss the results of her cholesterol test (which showed a reading of 6.9. It also emerges that the patient is also being managed by the GP for on-going health conditions which include chronic arthritis and a foot ulcer which is	The doctor does not explore the possible psychosocial reasons underlying her drinking behaviour but rather appears focused on quantifying how many units of alcohol she consumes and consequently forecloses any opportunity to follow up on the patient's underlying psychosocial reasons underlying her drinking/smoking.	Total cues= 10 No Positive Responses= 1 No Missed Responses= 9

<b>Professional Group</b>	<b>Study ID</b>	<b>Basic professional demographics</b>  <b>Patient or prescriber initiated consultation</b>	<b>Length of Consultation</b>	<b>Brief Description of Patients' Reason (s) for Visiting</b>	<b>Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation</b>	<b>Total Cues and Number of Positive &amp; Missed Responses Identified in Quantitative Phase</b>
				possibly linked to side effects of her medication for her arthritis. The conversation soon switches to the patient's alcohol consumption as a possible contributing factor to her higher cholesterol. During this conversation, it becomes evident that the patient is aware of and has been trying to reduce her consumption of alcohol and cigarettes and which have been a topic of		

<b>Professional Group</b>	<b>Study ID</b>	<b>Basic professional demographics</b>  <b>Patient or prescriber initiated consultation</b>	<b>Length of Consultation</b>	<b>Brief Description of Patients' Reason (s) for Visiting</b>	<b>Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation</b>	<b>Total Cues and Number of Positive &amp; Missed Responses Identified in Quantitative Phase</b>
				conversation in previous consultations.		
	213	GP Female 51 years Pt initiated	11.22	A female patient presents with sleeping difficulties caused by discomfort she is feeling after having had breast reconstructive surgery. The patient is also keen to address her sleeplessness soon as she is going on a cruise in the near future	GP responds empathically to the patient and conveys understanding of the impact of not sleeping on the patient's day-to-day life but overlooks a few c/c	Total cues= 9 No Positive Responses= 4 No Missed Responses= 5
	313	GP Male 43 years Pt initiated	12.38	A female patient who has persistent cold/flu symptoms and has already received several	The doctor is very empathic and is slightly reluctant to prescribe another course of antibiotics but involves the patient in the process and explains what her	Total cues= 5 No Positive Responses= 4 No Missed

<b>Professional Group</b>	<b>Study ID</b>	<b>Basic professional demographics</b>  <b>Patient or prescriber initiated consultation</b>	<b>Length of Consultation</b>	<b>Brief Description of Patients' Reason (s) for Visiting</b>	<b>Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation</b>	<b>Total Cues and Number of Positive &amp; Missed Responses Identified in Quantitative Phase</b>
				courses of antibiotics returns to her GP as she is still feeling unwell.	options are and is also very responsive and sympathetic to how unwell she feels.  From 5.30 he explains it could be either a virus or bacteria and then says 'my feeling is that I'm loathe to prescribe anything else to you because you've had so many antibiotics over the last month or so but you're still unwell, you've still got pain round the throat, you've got sinusitis, I'm going to have to go for something. I think it'll fix it but what I would say is hang on to it for a couple of days and if you think you're turning a corner, don't cash it in'	Responses= 1
	454	GP Male 50 years Pt initiated	7.78	A female patient visits her GP to seek reassurance following a visit to the audiologist.	The GP goes some distance to reassure the patient but does not always acknowledge her real concern about having a suspected benign brain tumour.	Total cues= 5 No Positive Responses= 3 No Missed

<b>Professional Group</b>	<b>Study ID</b>	<b>Basic professional demographics</b>  <b>Patient or prescriber initiated consultation</b>	<b>Length of Consultation</b>	<b>Brief Description of Patients' Reason (s) for Visiting</b>	<b>Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation</b>	<b>Total Cues and Number of Positive &amp; Missed Responses Identified in Quantitative Phase</b>
				<p>The patient relays that the audiologist recommended she have an MRI scan as he suspects she may have a brain tumour. The patient thinks this may be connected with a bang on the head she a few years ago.</p> <p>The patient has also had a series of 'biographical disruptions' and so the recent alarm has added to her pre-existing worries – just when she thought she was getting</p>		Responses= 2



<b>Professional Group</b>	<b>Study ID</b>	<b>Basic professional demographics</b>  <b>Patient or prescriber initiated consultation</b>	<b>Length of Consultation</b>	<b>Brief Description of Patients' Reason (s) for Visiting</b>	<b>Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation</b>	<b>Total Cues and Number of Positive &amp; Missed Responses Identified in Quantitative Phase</b>
				back to normal		
	281	GP Female years Pt initiated				Total cues= No Positive Responses= No Missed Responses=
Nurse Prescribers	977	NP Female 45 years Pt Initiated		A female patient comes in as she is experiencing chronic knee pain which she is concerned about and in considerable pain – sounds tearful during the consultation	The nurse is sympathetic but does not always acknowledge the patient's cues and occasionally interrupts the patient's narrative with biomedical questions. Frequent typing.	Total cues= 2 No Positive Responses= 1 No Missed Responses= 1
	92	NP Female 51 years	13.63	Medication Review A female patient receives a medication review for her asthma medication	The female patient is taking medication for wide-ranging chronic health problems and during the consultation communicates a range of cues and concerns relating to those conditions which are often	Total cues= 5 No Positive Responses= 1 No Missed Responses= 4

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					overlooked or inadequately addressed. The nurse appears to be very focused on adhering to the script and formula of a medication review and does not acknowledge the cues and concerns relating to the patient's health problems.	
	138	NP Female 47 years Pt initiated	9.80	The male patient has come in with blocked ears which are causing him some discomfort and is preventing him from sleeping properly	The nurse listens and responds empathically and provides the patient with space to talk. The nurse responds to the patient's c/c and goes off script to address them particularly as the patient appears to interrupt the nurse often. The consultation appears very routine and 'business-like'	Total cues= 5 No Positive Responses= 1 No Missed Responses= 4
	808	NP Female 53 years Pt-Pr initiated	12.85	The male patient has come in for general chat about lifestyle, blood pressure, cholesterol. Both patient and nurse	The nurse gives ample space for the patient's narrative. The patient communicates that he has a number of 'niggles' at the moment and discusses what he's been doing on the lifestyle front and how's he's managed his	Total cues= 10 No Positive Responses= 4 No Missed Responses=

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				are familiar with each other	stress levels by reducing his work commitments. The nurse is empathic and acknowledges his cues and concerns with some exceptions – one of these is a poignant reference to his dying father and underlying concerns he has about his cough which relate to witnessing his own father die from a 'coughing fit'	6
	553	NP Female 38 years Pt Initiated	4.92	A female patient describes symptoms consistent with having a cold but the symptoms are persistent. The woman also talks about her psychosocial world – she is stressed at work and is getting married in 3 weeks and, as a	The nurse is largely sympathetic but not always empathic – sticks to her script	Total cues= 6 No Positive Responses= 3 No Missed Responses= 3

Professional Group	Study ID	Basic professional demographics  Patient or prescriber initiated consultation	Length of Consultation	Brief Description of Patients' Reason (s) for Visiting	Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation	Total Cues and Number of Positive & Missed Responses Identified in Quantitative Phase
				result, is generally feeling run down.		
	236	Female 44 years Pt initiated	4.22	An elderly female patient presents with persistent flu like symptoms. Due to the severity and unprecedented nature of her symptoms, the patient is concerned that she may have had swine flu.	An elderly female patient presents with on-going flu like symptoms and is specifically concerned about her constricted breathing. In what sounds like a very hurried four minute consultation, the patient also conveys a range of cues and concerns relating to worries she has about going in to hospital to have knee surgery, about feeling unwell and being on her own, and that these events are taking place around Christmas time – 'and it would be Christmas wouldn't it?'  In this excerpt, the patient communicates a concern that she may have had swine flu due to the unprecedented severity of her	Total cues= 6 No Positive Responses= 2 No Missed Responses= 4

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					<p>symptoms to which the nurse prescriber responds by asking her for her finger (presumably to test her oxygen levels) and which she then follows up by asking the patient if she smokes. This excerpt is indicative of the way in which this particular nurse interacts with her patients.</p> <p>The nurse appears very task focused and addresses the patient's biomedical concerns without attending to or acknowledging the patients psychosocial concerns or offering any reassurance to the patient's underlying worries about whether or not she has swine flu. As a result the question 'do you smoke?' which follows the patients concerns about swine flu strikes a discordant note as it seems starkly incongruous within</p>	

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					the patient's wider psychosocial context about being unwell and feeling alone and perhaps isolated - a very task focused consultation	
	474	Female Nurse 55 years Pr initiated	22.38	Routine asthma clinic Female pt	The nurse's empathic response reflects that the nurse is capable of going 'off script' and doesn't always adhere to her clinical asthma/QoF box template. The nurse conveys empathy concerning the patient's lifeworld concerns by reflecting back what she's heard to her patient	Total cues= 5 No Positive Responses= 3 No Missed Responses= 2
	194	Female nurse 55 years Pt initiated	7.87	A female patient has been experiencing 'splitting' headaches related to a cold, possible sinus infection	The nurse is generally sympathetic but tends to stick to her script – her responses seems minimal	Total cues= 6 No Positive Responses= 3 No Missed Responses= 3
	632	Female nurse 54 years	15.88	Diabetes clinic in which female	The patient communicates that she is stressed as has found the	Total cues= 7 No Positive

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		Pr Initiated		patient raises lifeworld concerns about her daughter who is experiencing financial and marital problems	situation with her daughter 'traumatic' and communicates that she 'did not wish to wake up'. These are poignant cues and are not always responded to empathically – sounds like the nurse wishes to resume her tasks.	Responses= 1 No Missed Responses= 6
	745	Female nurse 56 years Pr Initiated	14.17	A female patient – medication review for blood pressure tablets and medication for glaucoma	Genuine responses and acknowledgement of some c/c e.g. the patient admits to strategically not taking her blood pressure when she goes out (because they're a diuretic and make her go to the loo) – the nurse communicates understanding of the patient's decision.  The nurse responds off-script but, at times, the consultation feels a bit rushed, giving little space for the patient's narrative – the patient expressed this cue during	Total cues= 3 No Positive Responses= 3 No Missed Responses= 0

Professional Group	Study ID	Basic professional demographics  Patient or prescriber initiated consultation	Length of Consultation	Brief Description of Patients' Reason (s) for Visiting	Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation	Total Cues and Number of Positive & Missed Responses Identified in Quantitative Phase
					an infrequent moment of space in the consultation - just as the nurse was re-entering the room.	
Pharmacist prescribers	848	Male pharmacist 43 years Pr Initiated	23.32	Female Patient Medication review This is a medication review for paracetamol used for managing knee pain and blood pressure tablets	The pharmacist appeared attentive to the patient's life world concerns and narrative by acknowledging the impact of the patient's knee pain and discomfort linked to lymphedema. Occasionally the pharmacist responded within a biomedical framework/script as perhaps he wasn't sure how to respond e.g. when the patient communicated concerns about weight gain linked to the side effects of steroids she had taken following a course of chemotherapy.	Total cues= 8 No Positive Responses= 8 No Missed Responses= 0
	862	Female pharmacist 38 years Pr Initiated	5.77	Female patient has come in for a regular blood pressure medication review	The consultation is very formulaic with the pharmacist stringently following a biomedical script with little opportunity for the patient to convey any concerns or ask questions. When questions are	Total cues= 0 No Positive Responses= 0 No Missed Responses=



Professional Group	Study ID	Basic professional demographics  Patient or prescriber initiated consultation	Length of Consultation	Brief Description of Patients' Reason (s) for Visiting	Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation	Total Cues and Number of Positive & Missed Responses Identified in Quantitative Phase
					asked by the pharmacist, they tend to be closed questions which provides the patient with limited opportunity to communicate	0
	942	Female Pharmacist 51 years Pr Initiated	14.32	Male patient has come in for his Metformin medication review related to his diabetes	The pharmacist is very personable and uses a more open, less formulaic style although still incorporating her medication review questions. She uses humour and engages with the patient on his level. Typing is minimal. During the consultation, the patient mentions that he has had a few panic attacks recently – the pharmacist explores this with him.  I feel she strikes the balance between delivering her own agenda and meeting the patient's.	Total cues= 3 No Positive Responses= 3 No Missed Responses= 0
	341	Male pharmacist	10.90	Male patient BP Medication	This is a very script run consultation – little off script	Total cues= 4 No Positive

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		52 years Pr Initiated		review	work, particularly in response to the patients c/c e.g. "I'm a natural worrier" Not much opportunity for the patient to ask questions – php doesn't ask the patient how's he's getting on with his bp tablets nor enquire if he has any questions. Patient communicates c/c relating to comments made about his fast heart beat during a stay in hospital to which the PhP does not respond to perhaps because he feels unable to do as it's out with his area although hypertension is his area of specialism	Responses= 2 No Missed Responses= 2
	1050	Female pharmacist 36 years  Pr Initiated	17.00	Medication review for COPD and blood pressure tablets for male patient who has been referred by his GP	The pharmacist sticks to the script – her medication review template which forecloses any opportunity for the patient to ask questions or communicate any c/c. The PhP also employs numerous closed questions which	Total cues= 9 No Positive Responses= 5 No Missed Responses= 4

<b>Professional Group</b>	<b>Study ID</b>	<b>Basic professional demographics</b>  <b>Patient or prescriber initiated consultation</b>	<b>Length of Consultation</b>	<b>Brief Description of Patients' Reason (s) for Visiting</b>	<b>Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation</b>	<b>Total Cues and Number of Positive &amp; Missed Responses Identified in Quantitative Phase</b>
					again forecloses opportunities for open communication	
	962	Female pharmacist 47 years Pr Initiated	9.17	Medication review for Paroxetine for female patient	<p>The pharmacist sticks to the script – her medication review template which forecloses any opportunity for the patient to ask questions or communicate any c/c. The PhP also employs numerous closed questions which again forecloses opportunities for open communication e.g. the patient associates the side effects of her paroxetine with her susceptibility to UTIs but the PhP does not pick up on the c/c</p> <p>The PhP does not enquire about how the patient's experiences of taking the medication</p>	<p>Total cues= 1 No Positive Responses= 0 No Missed Responses= 1</p>
	928	Male pharmacist 38 years Pr Initiated	10.95	Blood pressure medication review for male patient	The pharmacist provides the patient with space in the consultation to talk through his other health conditions which may impact on his blood	<p>Total cues= 2 No Positive Responses= 2 No Missed</p>

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					<p>pressure. The PhP responds with continuers and appears to be tracking the patient's narrative, doesn't interrupt nor bring the consultation back to his own agenda despite the possibility that the patient is talking about health conditions which are outside the PhP's area of competency. This demonstrates that the PhP is able to go off scripts while still maintaining a focus for pursuing his own agenda. In this consultation, it feels as if the patient has opportunities to communicate. Sounds more patient-led</p> <p>Perhaps he could have asked an open question about the beginning e.g. so, how are you getting on with your blood pressure tablets</p>	Responses= 0
	358	Female	32.33	Referral by GP for	This patient has been referred by	Total cues= 3

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		pharmacist 32 years Pr Initiated		suspected COPD – female patient	her GP to see the pharmacist prescriber in relation to the patient's breathlessness. The pharmacist prescriber specialises in managing chronic respiratory conditions including COPD and asthma. In the excerpt below (box X), the consultation opens by the pharmacist introducing herself and explaining why the patient has been referred and then immediately launches in to the consultation by asking a question about whether the patient has ever smoked. The consultation appears to be professionally led rather than patient centred. Little exploratory work or opportunities for the pt to say more her breathlessness and her understanding or beliefs about its causes and how it is impacting on her.	No Positive Responses= 3 No Missed Responses= 0

<b>Professional Group</b>	<b>Study ID</b>	<b>Basic professional demographics</b>  <b>Patient or prescriber initiated consultation</b>	<b>Length of Consultation</b>	<b>Brief Description of Patients' Reason (s) for Visiting</b>	<b>Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation</b>	<b>Total Cues and Number of Positive &amp; Missed Responses Identified in Quantitative Phase</b>
					<p>Although the pharmacist may not have intended the question 'have you ever smoked?' to be value laden, patients are not always aware of whether there is a moral agenda underpinning the question. There is also potential that the question may be attributing blame on the individual by implicitly or explicitly associating their smoking behaviour as the cause of their respiratory problems. The question may tick a QoF box and provide the health professional with possible causal explanations or may provide clinical information with which to inform a diagnosis or possible treatment but the question may be interpreted differently by patients. While it is important to ascertain whether or not a patient</p>	

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					has smoked, on a clinical basis, it needs to be guided by sensitivity and awareness of its possible meanings for patients and the possibility that the question may be value laden.	
	1098	Female pharmacist 41 years Pr Initiated	35.93	Medication review for blood pressure tablets and asthma inhalers for male patient	The pharmacist provides space in the consultation and responds well to her patient, tracking his narrative and responding off script.	Total cues= 2 No Positive Responses= 2 No Missed Responses= 0
	593	Female pharmacist 36 years Pr Initiated	23.72	Consultation to discuss high sugar levels, discussion around diet and implications of continued raised sugar levels – male patient	The pharmacist has excellent communication skills and appears to genuinely engage with the patient by mirroring the patient's humour, being able to go off script and respond empathically to the patient's difficulty and perhaps denial regarding dietary changes he would need to make in order to reduce his raised	Total cues= 8 No Positive Responses= 8 No Missed Responses= 0

<b>Professional Group</b>	<b>Study ID</b>	<b>Basic professional demographics</b>  <b>Patient or prescriber initiated consultation</b>	<b>Length of Consultation</b>	<b>Brief Description of Patients' Reason (s) for Visiting</b>	<b>Reason for Inclusion in Qualitative Analysis – A Summary of the Consultation</b>	<b>Total Cues and Number of Positive &amp; Missed Responses Identified in Quantitative Phase</b>
					sugar levels. The pharmacist balances the clinical aspects of the consultation, communicating dietary advice and the implications of having raised sugar levels with a degree of empathy and compassion for the patient who is struggling to make changes to his diet.	



## Appendix P

The following transcription conventions have been adapted from Heritage (2004).

- [ ] *Brackets*: Onset and offset of overlapping talk
- = *Equal sign*: Utterances are latched or ran together, with no gap of silence
- *Hyphen*: Preceding sound is cut off/self-interrupted
- (.) *Parentheses with a full-stop*: A micro-pause of less than 0.2 seconds
- : *Colon(s)*: Preceding sound is extended or stretched; the more the longer
- ↑word↓ *Up arrow/down arrow*: Increased pitch relative to surrounding talk
- ↓word↑ *Down arrow/up arrow*: Decreased pitch relative to surrounding talk
- . *Full stop*: Falling or terminal intonation
- , *Comma*: Continuing or slightly rising intonation
- ? *Rising intonation*
- Underlining: Increase volume relative to surrounding talk
- o soft *Degree signs*: Decreased volume relative to surrounding talk
- >fast< *Greater-than/less-than signs*: Increased pace relative to surrounding talk
- <slow> *Less-than/greater-than signs*: Decreased pace relative to surrounding talk
- .h *Superscripted full-stop preceding h's*: In breaths; the more the longer
- h *H's*: Outbreaths; the more the longer
- hah/heh *Laugh token*: Relative open or closed position of laughter
- (doubt) *Filled single parentheses*: Transcriptionist doubt about talk
- ((Cough)) *Filled double parentheses*: Scenic detail/event/sound not easily transcribed

## APPENDIX Q

### **Responding to emotions: lay/patient perspectives** (Deledda et al, 2013).

- looking for clues,
- using intuition,
- exploring concerns,
- letting patients convey concerns,
- providing time and space within the consultation to enable patients to express their concerns,
- listening to the patient,
- not interrupting when the patient expresses concerns,
- using silence,
- providing reassurance
- being empathic and assisting patients in managing emotional problems

### **'Tips' for doctors:** Bensing et al (2011)

- Introduce yourself with unknown patients
- Show patients they are welcome
- Keep eye contact
- Listen; don't interrupt the patient;
- Show compassion; be empathic;
- Pay attention to psychosocial issues
- Take your time; don't hurry
- Treat patient's as human beings and not a bundle of symptoms;
- Take the patient seriously
- Be honest without being rude;
- Avoid jargon, check the patient understands;
- Know your limits; know when you have to refer a patient
- Invest in a common agenda;
- Avoid disturbances by computer or telephone

### **Provide space not reduce it:**

- Avoid shutting the patient down
- Avoid reducing the space or opportunities for the patients to express their concerns and worries

(Mazzi et al, 2013)

## **Appendix R**

Ruth Riley, Marjorie C. Weiss, Jo Platt, Gordon Taylor, Susan Horrocks, Andrea Taylor, A comparison of GP, pharmacist and nurse prescriber responses to patients' emotional cues and concerns in primary care consultations, *Patient Education and Counseling*, Volume 91, Issue 1, April 2013, Pages 65-71, ISSN 0738-3991, <http://dx.doi.org/10.1016/j.pec.2012.11.009>

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## APPENDIX S

<b>I D #</b>	<b>Typ e</b>	<b>Gen der</b>	<b>A ge</b>	<b>Ethnici ty</b>	<b>Clinic Type</b>	<b>Trainin g</b>	<b>IMD Scor e</b>	<b>Location</b>
1	GP	M	62	White British	General		117	Semi-rural
2	GP	F	47	White British	General + Weight Management		117	Semi-rural
3	NP	F	37	White British	Minor ailments	Reading	117	Semi-rural
4	GP	M	42	White British	General		218	Town & Fringe
5	GP	M	44	Irish	General		218	Semi-rural
6	GP	F	49	White British	General		117	Urban
7	NP	F	51	White British	Asthma, Respiratory	Winches ter	117	Urban
8	GP	M	46	White British	General		225	Town & Fringe
9	NP	F	47	White British	Minor ailments	UWE	225	Town & Fringe
10	NP	F	48	White British	Minor ailments	Swindo n	225	Town & Fringe
11	GP	M	51	White British	General		144	Urban
12	NP	F	55	White British	Warfarin + Minor Ailments	Plymout h	144	Urban
13	GP	F	51		General		135	Sub-Urban
14	NP	F	44	White British	Minor ailments + triage	Glouces ter	135	Sub-Urban
15	GP	M	55	White British	General		67	Semi-rural
16	GP	F	58	White British	General		57	Urban
17	GP	F	40	White British	General		225	Town & Fringe
18	GP	M	43	White British	General		57	Urban
19	Ph P	M	52	White British	Hypertension	Reading	57	Urban
20	Ph P	F	32	Indian	COPD	KCL	120	Urban
21	GP	F	50	White British	General		57	Urban
22	CP	F	44	White British	Community Pharmacy			Town & Fringe

23	GP	F	47	Indian	General		215	Sub-Urban
24	NP	F	43	White British	Minor ailments + Asthma	UWE	215	Sub-Urban
25	GP	M	50	White British	General		144	Town & Fringe
26	NP	F	55	White British	Diabetes	Plymouth	144	Town & Fringe
27	Ph P	F	51	White British	Warfarin	Reading	283	Sub-Urban
28	NP	F	44	White British	Minor ailments	Gloucester	215	Town & Fringe
29	NP	F	40	White British	Minor ailments	UWE	57	Sub-Urban
30	NP	F	38	White British	Minor ailments + triage	Gloucester	215	Urban
31	NP	F	37	White British	Minor ailments	UWE	57	Urban
32	Ph P	F	36	White British	Medicines Review	Bath	57	Urban
33	GP	F	57	Other White	General		57	Urban
34	NP	F	54	White British	Minor ailments	Plymouth	192	Semi-rural
35	GP	M	53	White British	General		192	Semi-rural
36	GP	M	42	White British	General		146	Rural
37	NP	F	50	White British	Minor ailments	Plymouth	146	Rural
38	GP	M	42	White British	General		146	Rural
39	NP	F	38	White British	Minor ailments	Plymouth	146	Rural
40	NP	F	56	Irish	Minor ailments + triage	Reading	289	Town & Fringe
42	GP	M	53	White British	General		304	Sub-Urban
43	NP	F	53	White British	Blood Pressure Clinic	Gloucester	304	Sub-Urban
44	GP	M	52	White British	General - Duty		322	Urban
45	Ph P	M	43	Irish	Medicines Review	Bath	57	Urban
46	Ph P	F	38		Blood Pressure Clinic	Reading	57	Sub-Urban
47	NP	F	43	White British	Minor ailments + pill check	UWE	57	Urban
49	Ph P	M	38		Hypertension	Bath	57	Sub-Urban

50	Ph P	F	51	Indian	Diabetes	KCL	296	Urban
51	Ph P	F	47	Indian	COPD	KCL	134	Urban
52	NP	F	45		Generalist	Reading	314	Urban
56	Ph P	F	36	Other Asian	COPD	South Bank	158	Urban
57	Ph P	F	41	Indian	Blood Pressure Clinic	Bath	57	Urban
58	Ph P	F	41	White British	Medicines Review	KCL	68	Urban